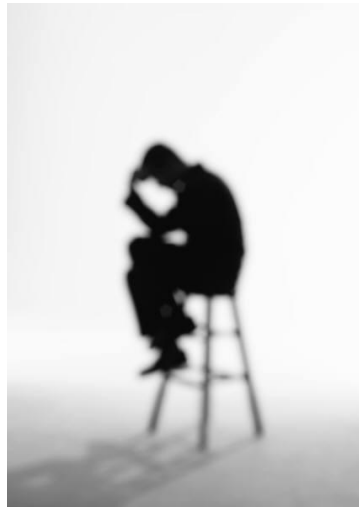


**M A B S S C O**

MID-AMERICAN BAPTIST  
SOCIAL SERVICE CORPORATION

# **Step North**

## ***Intake Packet***



**Step North**  
***Intake Packet***

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### Referral & Admission Checklist

|                        | Activity and/or Document   | Timing                       | Complete this Task  |
|------------------------|--|------------------------------|---|
| <b>Wkr/PO</b>          | <input type="checkbox"/> Receive initial referral call                                       | Before Admission             | Refer call to 1) Program Dir, 2) Community Mgr or 3)CEO   |
|                        | <input type="checkbox"/> Referral & Admission Documentation form                             | Before admission             | Ask referring agent to complete form.   |
|                        | <input type="checkbox"/> Placement authorization   | Before or at admission       | Obtain/request copy of court order or other legal placement doc.  |
|                        | <input type="checkbox"/> Obtain/request copy of outside screens/assessments/reports          | At admission                 | Ask referring agent to bring or send copies of available documents.   |
| <b>All</b>             | <input type="checkbox"/> Information Packet Receipt form                                     | Before or at admission       | Distribute information packets as needed.   |
|                        | <input type="checkbox"/> Preparing to Develop a TX Plan                                      | At admission                 | Gather info to help complete the first page of the treatment plan.  |
|                        | <input type="checkbox"/> Treatment Plan form   | At admission                 | Get info needed to complete the first page of the TX Plan at intake.  |
|                        | <input type="checkbox"/> Resident's Family/Approved Supporter Involvement Screen             | At admission                 | Identify family and other key support person involvement.   |
|                        | <input type="checkbox"/> Vulnerability Assessment and Sexually Abusive Behavior Screen       | Before or at admission       | Use to screen for safety related issues for youth or others.  |
| <b>Parent/Guardian</b> | <input type="checkbox"/> Notice of Privacy Practices   | At first contact             | Summarize how we protect private info; ask for signatures   |
|                        | <input type="checkbox"/> Acknowledgement of Receipt of Notice of Privacy Practices           | At first contact             | Ask for signature to show client/parent have a copy of notice.  |
|                        | <input type="checkbox"/> Authorization to Use/Disclose Health Information--Program Form      | Before or at admission       | Explain "participating organizations"; ask for needed signatures.   |
|                        | <input type="checkbox"/> Authorization to Use/Disclose Health Information--General Form      | Before or at admission       | If needed to get info, complete and ask for needed signatures.  |
|                        | <input type="checkbox"/> Research Authorization  | Before or at admission       | Explain use of info to evaluate services; ask needed signatures.  |
|                        | <input type="checkbox"/> Medical Authorization & Health Insurance Information form           | Before or at admission       | Authorizes routine and emergency care with client/parent signature. Get copy of both sides of insurance/MA cards. |
|                        | <input type="checkbox"/> Health Screen   | Within 24 hours              | This info helps us to follow-up on current and future medical needs.  |
|                        | <input type="checkbox"/> Education Screen  | Within 24 hours              | Info to help with enrollment and/or support for school success.   |
|                        | <input type="checkbox"/> Activity Authorization  | Before or at admission       | Authorizes youth participation in activities with needed signatures.  |
|                        | <input type="checkbox"/> Local Travel Authorization  | Before or at admission       | Authorizes us to transport youth with parent/guardian signature.  |
|                        | <input type="checkbox"/> Family Grievance Procedure  | At admission                 | Describes process for parent/guardian if not satisfied with services.   |
| <b>Young Person</b>    | <input type="checkbox"/> "Thinking About..." forms   | Before or at admission       | Youth completes these beginning first day—make copies for file.   |
|                        | <input type="checkbox"/> Resident's Basic Rights   | Before or at admission       | Review with youth and ask for signature.  |
|                        | <input type="checkbox"/> Rules of Conduct, Consequences & Restoration                        | Before or at admission       | Review with youth and ask for signature.  |
|                        | <input type="checkbox"/> Understanding Rights, Privileges & Responsibility                   | Before or at admission       | Review with youth and ask for signature.  |
|                        | <input type="checkbox"/> Resident Grievance Procedure  | Before or at admission       | Review with youth and ask for signature.  |
|                        | <input type="checkbox"/> Personal Property Policy  | Before or at admission       | Review with youth and ask for signature.  |
|                        | <input type="checkbox"/> Personal Property Inventory   | At admission                 | Complete inventory of possessions and have them sign.   |
| <b>Staff</b>           | <input type="checkbox"/> Referral & Admission forms in 3-ring binder                         | Before admission             | Use to keep documents together for signatures at Intake and to set-up client file.                                |
|                        | <input type="checkbox"/> Checklist of Approved Screenings for all Child Residential Settings | At admission                 | Complete this checklist within six working days of admission.   |
|                        | <input type="checkbox"/> Other screens: POSIT, Culture and Gender Specific Needs             | Start by 3, finish by 6 days | Computer or paper for POSIT. All staff document for Gender Needs Screen   |
|                        | <input type="checkbox"/> Program Specific Forms/Information                                  | At admission                 | Complete any program specific documents as required.  |

**Referral & Admission Documentation**

Referring Agent: \_\_\_\_\_ Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Referring Agent Supervisor: \_\_\_\_\_ Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Emergency After-Hours Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Client Name:** \_\_\_\_\_ Nicknames: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age at Admit: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Admit Date: \_\_\_\_\_ Admit Time: \_\_\_\_\_ Legal Authority for Placement: \_\_\_\_\_

Race or Cultural Heritage: \_\_\_\_\_ Tribal Affiliation: \_\_\_\_\_

Languages the resident speaks and writes: \_\_\_\_\_

Language the family speaks and writes: \_\_\_\_\_ Will an interpreter be needed? \_\_\_\_\_

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

**Placement Critical Goals or Issues:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Presenting Challenges/Concerns**

- Medical: \_\_\_\_\_
- Circumstances leading to admission: \_\_\_\_\_
- Mental Health: \_\_\_\_\_
- Safety: \_\_\_\_\_
- Other: \_\_\_\_\_

**Assets and Strengths** (include related information from resident, resident's family, and concerned persons in the resident's life):

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



# WELCOME

## to MABSSCO Step North!

### Our Mission

Our mission is to work with young adults to create solid foundations for a safe and healthy life on their own, in community with others.

### Five Treatment Phases towards Independence

Each young man participates in a variety of experiences designed to support a successful transition to life on his own by completing the following five treatment phases during the time they are with us:

#### 1. Roadmap

***Develop a treatment plan and begin to implement it.***

- Begin developing a tested safety and support network of caring people.
- Begin ILS activities including vocational assessment and employability skills training.
- Get a job and enroll in school (if part of your plan).

#### 2. Practice

***Practice new skills and strategies.***

- Test and practice skills to achieve treatment plan goals in a structured and supportive setting.

#### 3. Challenge

***Take on more challenging opportunities to practice skills.***

- Participate in our in-program apartment living simulation.
- Develop a Transition Plan and begin to implement it.

#### 4. Transition

***Implement the transition plan.***

- Continue practicing, demonstrating and honing your skills by implementing the transition plan.
- Begin or continue visits to community housing, use new modes of transportation, continue to test your support network, meet roommates and other community experiences.

#### 5. Aftercare

***Begin post-discharge community based support.***

- Work with the MABSSCO Aftercare Coordinator for up to six months.
- Participate in a six month follow-up evaluation and determine if additional support is needed.

### Expected Outcomes

**We expect a young man to achieve the following outcomes as he transitions to life on his own:**

- Have a safety and support network of caring people he can count on.
- Find a steady, satisfying job that matches his vocational strengths and preferences.
- Have a workable budget to sustain him.
- Live in safe, affordable housing.
- Maintain law abiding behavior in his community.
- Participate in a healthy way in the life of his community.



## **Preparing to Develop a Treatment Plan**

Ask for the perspectives of youth, family, referring agent and any other community treatment team member present.

**What is going well?** (Include strengths and willingness to work--identify youth and parent views)

**What are we worried/concerned about?** (Identify youth, parent and referring agent views)

**What are our best hopes for safety, permanency and well-being?** (Identify youth, parent and referring agent views)

**What do we need to do next?** (Identify and discuss "Placement Critical Goals" and other goals at Intake)

## Treatment Plan

|                                  |                         |   |
|----------------------------------|-------------------------|---|
| Young Person:                    | Date of Birth:          | Gender: <input type="checkbox"/> M <input type="checkbox"/> F |
| Admit Date:                      | TX Plan Dev Start Date: | Last Review Date:   |
| <b>Projected Discharge Plan:</b> |                         |   |

**About DSM-IV**

No DSM-IV diagnosis.

DSM-IV diagnosis date:

|   |                  |
|---|------------------|
| <b>Axis I</b> identifies clinical disorders, including substance-related disorders, except personality disorders and mental retardation.  | <b>Axis I:</b>   |
| <b>Axis II</b> identifies personality disorders and intellectual disabilities.  | <b>Axis II:</b>  |
| <b>Axis III</b> describes general medical conditions potentially relevant to the understanding or management of the mental disorder.  | <b>Axis III:</b> |
| <b>Axis IV</b> identifies psychosocial and environmental problems that may affect diagnosis and treatment.  | <b>Axis IV:</b>  |
| <b>Axis V</b> is the <i>Global Assessment of Functioning Scale (GAF)</i> , a scale that indicates a clinician's overall judgment of a person's psychological, social, and occupational functioning. | <b>Axis V:</b>   |

No Meds     Current Meds

| Med Name | Dosage | Desired Results from Meds | Report These Reactions to MD |
|----------|--------|---------------------------|------------------------------|
|          |        |                           |                              |
|          |        |                           |                              |
|          |        |                           |                              |

The answers to the following four questions assist us in deciding what to do next and in developing clear, agreed upon placement critical goals, measurable objectives, sound treatment strategies and accountability for them:

**1. What is going well?**

**2. What are we concerned about?**

**3. What are our best hopes for safety, independence and well-being?**

**4. What do we do next?** The question the Treatment Plan addresses.

***Placement Critical Goal #1:***

**Measurable/Observable Objective(s):**

**Treatment Strategy:**

**Schedule to Achieve:**

**Entities Responsible:**

**Monthly Review/Date:**

***Placement Critical Goal #2:***

**Measurable/Observable Objective(s):**

**Treatment Strategy:**

**Schedule to Achieve:**

**Entities Responsible:**

**Monthly Review/Date:**

***Placement Critical Goal #3:***

**Measurable/Observable Objective(s):**

**Treatment Strategy:**

**Schedule to Achieve:**

**Entities Responsible:**

**Monthly Review/Date:**

What do we do next?

**Placement Critical Goal #4:**

Measurable/Observable Objective(s):

Treatment Strategy:

Schedule to Achieve:

Entities Responsible:

Monthly Review/Date:

**Health Goal:**

Objective(s):

Treatment Strategy:

Schedule to Achieve:

Entities Responsible:

Monthly Review/Date:

**Safety/Risk Management Goal:**

Objective(s):

Treatment Strategy:

Schedule to Achieve:

Entities Responsible:

Monthly Review/Date:

What do we do next?

***Mental Health/Developmental Goal:***

**Objective(s):**

**Treatment Strategy:**

**Schedule to Achieve:**

**Entities Responsible:**

**Monthly Review/Date:**

***Family Goal:***

**Objective(s):**

**Treatment Strategy:**

**Schedule to Achieve:**

**Entities Responsible:**

**Monthly Review/Date:**

***Education/Employment Goal:***

**Objective(s):**

**Treatment Strategy:**

**Schedule to Achieve:**

**Entities Responsible:**

**Monthly Review/Date:**

What do we do next?

**Cultural/Spiritual Goal:**

Objective(s):

Treatment Strategy:

Schedule to Achieve:

Entities Responsible:

Monthly Review/Date:

**Gender-Specific Goal:**

Objective(s):

Treatment Strategy:

Schedule to Achieve:

Entities Responsible:

Monthly Review/Date:

**Recreational Goal:**

Objective(s):

Treatment Strategy:

Schedule to Achieve:

Entities Responsible:

Monthly Review/Date:

|               |
|---------------|
| Young Person: |
|---------------|

**What do we do next?**

|   |
|---|
| <p><b>Aftercare Goal:</b></p> <p><b>Objective(s):</b></p> <p><b>Treatment Strategy:</b></p> <p><b>Schedule to Achieve:</b></p> <p><b>Entities Responsible:</b></p> <p><b>Monthly Review/Date:</b></p> |
|---|

|  |
|--|
| <p><b>Use of Restrictive Procedures:</b> MABSSCO group residential facilities are certified to use the restrictive procedures “physical holding” and “physical escort”. While at one of our facilities, a restrictive procedure will only be used with a resident if in accordance with the treatment plan and MABSSCO restrictive procedure plan.</p> <p>With this resident, use of restrictive procedures when circumstances meet the standards outlined in MABSSCO’s Restrictive Procedures Plan is subject to the following decision (check one):</p> <p><input type="checkbox"/> Approved    <input type="checkbox"/> Approved with the following limitations: _____</p> <p>_____</p> <p><input type="checkbox"/> Not approved    Comments: _____</p> |
|--|

**Community Treatment Team (CTT) Review and Signatures:**

| CTT Member Name                 | Signature | Date |
|---------------------------------|-----------|------|
| Young Person:                   |           |      |
| Parent/Guardian/Caregiver:      |           |      |
| Parent/Guardian/Caregiver:      |           |      |
| MABSSCO Case Coordinator:       |           |      |
| MABSSCO Program Director:       |           |      |
| MABSSCO ILS Manager:            |           |      |
| County Worker:                  |           |      |
| Probation Officer:              |           |      |
| Guardian Ad Litem:              |           |      |
| Community Therapist:            |           |      |
| MABSSCO Aftercare Coordinator:  |           |      |
| MABSSCO Employment Coordinator: |           |      |
| Community Specialist:           |           |      |
| Other:                          |           |      |

*Revised 6/7/06, 7/2/06, 1/29/07, 10/29/07, 9/08*

**Resident’s Family/Approved Supporter Involvement Screen**

Young Adult: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Screen: \_\_\_\_\_

**Instructions:** Document the inquiries and results of the inquiries regarding the degree to which the resident’s family/approved\* supporter wants to be involved during the resident’s stay at Step North.

| Family/Supporter Name   | Relationship | Date Contacted | Contact Info |
|---|--------------|----------------|--------------|
| 1.  |              |                |              |
| Involvement desired (check all that apply):<br><input type="checkbox"/> Visits <input type="checkbox"/> Phone <input type="checkbox"/> E-mail <input type="checkbox"/> Family/Supporter Events <input type="checkbox"/> Planning Meetings <input type="checkbox"/> Other<br><input type="checkbox"/> Transportation Assistance <input type="checkbox"/> Mentoring <input type="checkbox"/> Housing <input type="checkbox"/> Employment <input type="checkbox"/> Support Network |              |                |              |
| 2.  |              |                |              |
| Involvement desired (check all that apply):<br><input type="checkbox"/> Visits <input type="checkbox"/> Phone <input type="checkbox"/> E-mail <input type="checkbox"/> Family/Supporter Events <input type="checkbox"/> Planning Meetings <input type="checkbox"/> Other<br><input type="checkbox"/> Transportation Assistance <input type="checkbox"/> Mentoring <input type="checkbox"/> Housing <input type="checkbox"/> Employment <input type="checkbox"/> Support Network |              |                |              |
| 3.  |              |                |              |
| Involvement desired (check all that apply):<br><input type="checkbox"/> Visits <input type="checkbox"/> Phone <input type="checkbox"/> E-mail <input type="checkbox"/> Family/Supporter Events <input type="checkbox"/> Planning Meetings <input type="checkbox"/> Other<br><input type="checkbox"/> Transportation Assistance <input type="checkbox"/> Mentoring <input type="checkbox"/> Housing <input type="checkbox"/> Employment <input type="checkbox"/> Support Network |              |                |              |
| 4.  |              |                |              |
| Involvement desired (check all that apply):<br><input type="checkbox"/> Visits <input type="checkbox"/> Phone <input type="checkbox"/> E-mail <input type="checkbox"/> Family/Supporter Events <input type="checkbox"/> Planning Meetings <input type="checkbox"/> Other<br><input type="checkbox"/> Transportation Assistance <input type="checkbox"/> Mentoring <input type="checkbox"/> Housing <input type="checkbox"/> Employment <input type="checkbox"/> Support Network |              |                |              |

\* “approved” means that parent/guardian and/or referring agent support this person having contact with a resident.

\_\_\_\_\_  
Signature of staff member who completed the screen

\_\_\_\_\_  
Date

**Vulnerability Assessment and Sexually Abusive Behavior Screen**

Youth Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Does this child have a history of abuse? If so, check abuse type(s) and note gender of abuser and relationship to child:

\_\_\_ physical abuse \_\_\_\_\_

\_\_\_ emotional abuse \_\_\_\_\_

\_\_\_ sexual abuse \_\_\_\_\_

\_\_\_ No history of abuse reported or documented.

Does the child have a history of vulnerability such as being teased, picked on, or other indications of potential safety issues with other residents? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does the child have a history of victimizing others? If so, check abuse type and note gender of victim and relationship to child:

\_\_\_ physical abuse \_\_\_\_\_

\_\_\_ emotional abuse \_\_\_\_\_

\_\_\_ sexual abuse \_\_\_\_\_

Does the child's history indicate the need for special precautions or particular staffing patterns in the facility? \_\_ Yes \_\_\_\_\_ No

**The facility must develop written risk reduction measures to minimize the potential for further abuse in the facility and in the community.**

\_\_\_\_\_  
Signature of staff member who completed the screen

\_\_\_\_\_  
Date

## Notice of Privacy Practices

*This notice is effective April 14, 2003, and governs our privacy practices on and after that date.*

### **Notice Information**

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

Federal and state privacy and medical records laws protect your rights as a client of MABSSCO. This notice applies to your current contact with MABSSCO and all future contacts, whether the contact is in person, by telephone, or by mail.

A federal law, the Health Insurance Portability and Accountability Act of 1996, requires us to give you this Notice of Privacy Practices. This Notice applies to health information about you called protected health information or PHI.

This Notice describes uses and disclosures we may make and gives some examples. We will make reasonable efforts to limit PHI use and disclosure to the minimum necessary. This Notice also describes your rights to see PHI and other rights you have.

### ***What is Protected Health Information (PHI)?***

PHI is health information about you that can be used to identify you. This information relates to your past, present, or future physical or mental health or condition, related health care services, and payment. We must:

1. Make sure we keep PHI private.
2. Give you the Notice about our legal duties and privacy practices concerning PHI.
3. Follow the terms of the current Notice.
4. Make changes in the Notice available to you.

### ***Current Notice***

We reserve the right to change our privacy practices and the terms of our Notice at any time. Any change is effective for PHI we have as well as future PHI. We will post the current Notice. You can get a current copy by asking for one. You also can see a current copy of our Notice on the MABSSCO web site at [www.mabssco.org](http://www.mabssco.org).

### ***Who Will Follow This Notice***

This Notice describes PHI privacy practices for MABSSCO. MABSSCO includes the following:

1. **Residential Services:**  
MABSSCO Step North.
2. **Community Services:**  
Work with youth and families through the Independence Partnership program and other community based services.
3. **Related Services** provided to MABSSCO residential and community services by other MABSSCO staff or consulting staff such as accounting, audit, and risk management, cultural, clinical and nursing consultation.

### ***How MABSSCO May Use or Disclose Protected Health Information***

#### ***Required Disclosures***

By law, we must disclose PHI to you upon request. We also must disclose PHI to the Secretary of U.S. Department of Health and Human Services for investigations or to determine compliance with laws protecting PHI.

#### ***Permitted Uses and Disclosures***

##### ***Treatment***

We will use and disclose PHI when we are giving you services. This may include coordinating or managing your care with a third party. For example, we may disclose PHI to a MABSSCO contractor who provides care to you. When allowed by Minnesota law, we may disclose PHI to another health care provider, such as a laboratory helping with your treatment, who is involved in your care. In emergencies, we will use and disclose PHI to provide treatment you require.

##### ***Payment***

We will use and disclose PHI to get paid for services. This includes finding out if you have medical assistance coverage. For example, MABSSCO may disclose PHI to Minnesota Department of Human Services to get paid for services we provide you.

### ***Health Care Operations***

We may use or disclose PHI to support activities in order to manage our programs. These activities may include:

1. Quality assessment.
2. Investigating and training employees.
3. Employee performance reviews.
4. Licensing or accreditation.
5. Letting you know about a product or service.
6. Other health care related activities.

For example, we may disclose PHI to a nurse consultant seeing a MABSSCO client. We may share PHI with business associates (for example, an interpreter). We require business associates by agreement to protect PHI.

We may call you by name in a waiting area when your MABSSCO staff person is ready to see you. We may use PHI to contact you to remind you about your appointment.

We may use PHI to tell you about treatment alternatives that might interest you. For example, we may use your name and address to send you a newsletter about MABSSCO and the services we offer. We also may send other information we believe might help you.

### ***Required by Law***

We may use or disclose PHI when a federal or state law or regulation requires.

### ***Public Health***

We may disclose PHI to a public health authority as permitted by law. For example, we may disclose PHI to:

1. Assist in preventing or controlling disease, injury, or disability.
2. Report child abuse or neglect.
3. Report reactions to medications or problems with products.
4. Notify a person who may be exposed or at risk to contract or spread a disease.
5. Notify appropriate government authority if we believe someone is the victim of abuse, neglect, or domestic violence.

### ***Health Oversight***

We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Health oversight agencies include government agencies that oversee the health care system, benefit programs, and other regulatory programs, such as civil rights laws.

### ***Legal Proceedings***

We may disclose PHI during a judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process. For example, a court order or law may require sharing PHI with the court and attorneys for a juvenile court proceeding.

### ***Law Enforcement***

We may disclose PHI for law enforcement purposes when allowed by Minnesota law, including the following:

1. Responses to legal proceedings.
2. Circumstances pertaining to victims or to crimes occurring at a MABSSCO site.
3. Medical emergencies.

### ***Coroners***

We may disclose PHI to coroners or medical examiners: to identify the individual, to determine cause of death, or to perform other duties authorized by law.

### ***Research***

We may disclose PHI to researchers when authorized by law. For example, if an institutional review board reviewed the research proposal, set privacy protocols, and approved the research. Under Minnesota law, a researcher also signs a nondisclosure agreement.

### ***Criminal Activity***

We may disclose PHI when we believe necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. When allowed by Minnesota law, we may disclose PHI needed for law enforcement to identify or apprehend an individual.

### ***Specialized Government Functions, including National Security***

We may disclose PHI to Federal officials conducting national security and intelligence activities. This includes protective services to the President or others. We may disclose PHI for military and veterans' activities if you are or were in the armed forces. We may disclose PHI for medical suitability decisions of the U.S. Department of State.

### ***Inmates***

In some situations, we may disclose PHI about you to a correctional institution having lawful custody of you:

1. For the institution to give you health care.
2. For the health and safety of you or others.
3. For the safety and security of the institution.

### ***Parental Access***

Minnesota law requires us to disclose PHI to parents, guardians, and persons acting in a similar legal status in most situations. We will act consistent with Minnesota law.

### ***Personal Representatives***

A personal representative is a parent or a legal guardian appointed by the court or someone you choose as power of attorney to act on your behalf. MABSSCO will ask for written proof that a person qualifies before allowing them to see PHI.

## ***Uses and Disclosure to Which You May Object***

### ***Individuals Involved in Your Health Care***

When allowed by Minnesota law we may disclose PHI to a family member or other person you identify as directly involved in your health care. For example, you may wish to have someone in the room with you.

We may disclose PHI to notify a family member, personal representative, or any other person who is responsible for your care, about your location, general condition, or death. We may disclose PHI to assist in disaster relief efforts and coordinate disclosures to family or other individuals involved in your health care.

### ***Other Situations Require Your Authorization***

MABSSCO will ask you to give us written authorization before using or disclosing PHI for other situations. This is informed consent under Minnesota law. For example, if your MABSSCO staff person talks about a program and wants to send PHI to make a referral, we will ask for your consent. You may revoke your consent in writing at any time for any future disclosure. You may give any one you wish consent to see and have copies of your PHI. You must do this in writing.

## ***Your Rights Regarding Your Health Information***

You can exercise your rights by sending a written request to MABSSCO, Attn: Privacy Officer, P.O. Box 330, Victoria, MN 55386.

### ***Right to Inspect and Copy***

You may see and get a copy of your PHI as long as we have the PHI. This does not include investigative data for a civil, criminal, or administrative proceeding or PHI subject to a law that prohibits access. You may have to pay for copies.

### ***Right to Request Restrictions***

You may ask us to restrict uses or disclosures of any part of PHI for treatment, payment, or health care operations or for others involved in your care. In your request, you must tell us:

1. What information you want restricted;
2. Whether you want to restrict our use, disclosure, or both;
3. To whom you want the restriction to apply; and
4. An expiration date for the restriction.

If we do not think it is in your best interest or cannot conform to the request, we do not have to agree. If we agree, we will only use or disclose PHI as restricted, except to provide emergency treatment. You may revoke a restriction at any time, in writing.

### ***Right to Request Confidential Communications***

You may ask us to contact you using different means or location. You must make the request in writing. You must specify an alternative address or other method of contact. We will not ask you why. For example, you can ask us to send mail to a Post Office box or work address instead of home address. We will accommodate reasonable requests.

### ***Right to Request Amendment***

If you think PHI is incorrect or incomplete, you may ask us to amend PHI. We do not have to amend PHI that we think is correct. You also can challenge data accuracy and completeness under the Minnesota Government Data Practices Act.

**Right to an Accounting of Disclosures**

You may ask in writing for an accounting of PHI disclosures we have made. This does not apply to disclosures: made for, or incidental to, treatment, payment, or health care operations; or made to you, to people involved in your care, or to others with your consent. Accounting only applies to disclosures after April 14, 2003, and no more than 6 years before the request date.

**Right to Obtain a Copy of this Notice**

You may get a paper copy of the current Notice from the MABSSCO employee who is working with you. You may view it electronically at the MABSSCO web site [www.mabssco.org](http://www.mabssco.org).

**Complaints**

If you think we violated your privacy rights, you may file a written complaint with the MABSSCO Privacy Official or with the U.S. Department of Health and Human Services. MABSSCO will not take action against you for filing a complaint or for exercising any other right. To file a complaint with the MABSSCO Privacy Officer, you must send the complaint in writing to MABSSCO, Attn: Privacy Officer, P.O. Box 330, Victoria, MN 55386.

**Other Contact Information**

You may contact the MABSSCO Privacy Officer with questions by phone at 952-443-5002.

**Privacy Laws**

We provide this Notice as required under federal law. Several other privacy laws also may apply, such as the Minnesota Government Data Practices Act. We considered these laws in developing our privacy practices and this Notice. We also give you a notice about data practices when required to do so by Minnesota law.

**Why do we ask for information?**

WE ask for information from you to determine what service or help you need, develop a service plan with you, and give you the services you want.

The information may also be used to determine your charges for services or for collection of payment from insurance companies or other payment sources.

**Do you have to give information to us?**

There is no law that says you must give us any information. However if you choose to not give us some information, it can limit our ability to serve you well.

**What will happen if you do not answer the questions we ask?**

If you are here because of a court order, and you refuse to provide information, that refusal may be communicated to the Court.

Without certain information, we may not be able to tell who should pay for your services.

**What privacy rights do minors have?**

If you are under 18 years old, you may request that information about you be kept from your parents. You must give us your request in writing, describe the information, and tell us you don't want your parents to see it.

If, after reviewing your request, MABSSCO staff believe that giving the information to your parents is not in your best interest, we will not share the information. If MABSSCO staff believe this information could be safely shared with your parents, we will inform you of that decision.

If you are 16 years old, you may ask for mental health services without the consent of your parents, but you may have to pay for the services if you do not want your parents to know.

**Please sign this form and keep a copy of the form. Your signature shows that we have informed you of your privacy rights and that you are aware of the possible uses and disclosures of your protected health information.**

|  |       |
|--|-------|
| _____                                      | _____ |
| Client Signature                           | Date  |
| _____                                      | _____ |
| Personal Representative/Guardian Signature | Date  |
| _____                                      | _____ |
| Witness Signature                          | Date  |

Revised 5/08

**Acknowledgement of Receipt of Notice of Privacy Practices**

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of MABSSCO. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website at [www.mabssco.org](http://www.mabssco.org) or by calling MABSSCO at (952) 443-5002. If you have any questions about our *Notice of Privacy Practices*, please ask your MABSSCO staff.

I acknowledge receipt of the *Notice of Privacy Practices* of MABSSCO.

|   |       |
|---|-------|
| Print Name of Individual (or Legal Representative): |       |
| Signature of Individual (or Legal Representative):  |       |
| If Legal Representative, give relationship:         | Date: |

**Inability to Acknowledge Receipt of Privacy Practices**

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

- Individual refused to sign.
- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (specify) \_\_\_\_\_

|                                      |
|--------------------------------------|
| Signature of MABSSCO Representative: |
| Date:                                |

**Authorization to Use/Disclose Health Information—Program Form**  
*For use under the HIPAA Privacy Rule and Minnesota Law*

This authorization is required under the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule for uses and disclosures of protected health information not otherwise allowed by the Privacy Rule.

To Parents/Guardian:

Your son/daughter/ward has the opportunity to receive services through Mid-American Baptist Social Service Corporation (MABSSCO) programs (MABSSCO Step North, MABSSCO Independence Partnership). These programs involve the following Participating Organizations: Placing County’s Human Services/Court Services/Probation Department, The Jonas Center (Clinical Consultant), Connected Families (Clinical Consultant), Health Counseling Services, Inc. (Nurse Consultant), Haven Chemical Health Systems, LLC (The Haven in Waconia, MN), Local Employer of your child. Staff from MABSSCO and the Participating Organizations may work together in the treatment of your child. The information collected in MABSSCO programs about your child may be covered by laws governing data privacy. Because program staff work for both MABSSCO and the Participating Organizations, your permission is needed to allow them to share information with each other about your child.

By signing this form, you give your permission for the staff in a MABSSCO program and the Participating Organizations to share the types of information listed below. The purpose of sharing this information is to allow staff from MABSSCO and the Participating Organizations to work together to provide appropriate care and treatment services for your child. You are not required to provide your permission, but your child may not be able to participate or receive full services from the program unless you do.

|                   |               |                        |
|-------------------|---------------|------------------------|
| Child’s Full Name | Date of Birth | Social Security Number |
|-------------------|---------------|------------------------|

I understand the information to be shared between MABSSCO and the Participating Organizations includes information received from other organizations or health providers if such information has been integrated into and made part of the records of either MABSSCO or the Participating Organizations according to the policies of the Program.

**I authorize staff in MABSSCO residential programs and Participating Organizations to release and/or exchange the following types of information with each other (check all that apply):**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Medical Reports/health history  | <input type="checkbox"/> Chemical dependency history/evaluations | <input type="checkbox"/> Summary of medications     |
| <input type="checkbox"/> Court or probation records  | <input type="checkbox"/> Recommendations for treatment or care   | <input type="checkbox"/> School reports/records     |
| <input type="checkbox"/> Life skills assessment(s)   | <input type="checkbox"/> Family history/issues                   | <input type="checkbox"/> Staff observations/reports |
| <input type="checkbox"/> Psychological/Intellectual assessment(s)/reports                            |  | <input type="checkbox"/> Work schedules             |
| <input type="checkbox"/> Summary of presenting problem(s), diagnostic findings, treatment, discharge |  | <input type="checkbox"/> Work observations/reports  |
| <input type="checkbox"/> Other _____   |  |   |

**This information will be used and/or disclosed for the following specific purpose(s):**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Fundraising            | <input type="checkbox"/> Health plan sponsor   | <input type="checkbox"/> Individuals involved in your care or payment for your care |
| <input type="checkbox"/> Research               | <input type="checkbox"/> Marketing             | <input type="checkbox"/> At your request to a third party specified by you          |
| <input type="checkbox"/> Employer               | <input type="checkbox"/> Workers’ compensation | <input type="checkbox"/> To provide treatment                                       |
|   |  | <input type="checkbox"/> To support employment success                              |
| <input type="checkbox"/> Other (describe) _____ |  |   |

**Please Note:**

- The information to be used or disclosed may no longer be protected under the terms of the federal privacy rule once it is used or disclosed in accordance with this authorization.
- MABSSCO will not condition treatment or coverage on your providing this authorization.

I further understand that I may revoke this authorization at any time, except not retroactively, by giving written notification to MABSSCO at P.O. Box 330, Victoria, MN 55386, Attention: Records, Phone: (952) 443-5002.

If not previously revoked, this authorization will terminate within one year from the signing of this authorization,

\_\_\_\_\_, whichever comes first, or as authorized by law.  
(specific date, event, or condition)

I understand that I will be provided with a copy of this signed authorization.

I deny the use or disclosure of my personal health information for the purpose(s) listed on this form.

I recognize that the Mid-American Baptist Social Service Corporation (MABSSCO) cannot guarantee the privacy of information released by it under this authorization, but it is my intent that the party I authorize to receive it will consider it private. I understand that information to be release by MABSSCO includes information received from other organizations or health providers if such information has been integrated into and made part of the records of MABSSCO according to its policies.

I acknowledge that release of the information constitutes waiver for the limited purpose designated herein of any therapist/client privilege or right to confidentiality that I may have under law.

|                  |  |         |
|------------------|--|---------|
| Client Signature | Personal Representative or Legal Guardian (if minor) | Witness |
| Print Name       | Print name   | Date    |
| Date             | Date   |         |

**If you are signing as a personal representative for an individual, read and sign below:**

I, \_\_\_\_\_, hereby certify and attest that I am the duly authorized personal representative of \_\_\_\_\_ and that I have the lawful authority to enter into this authorization on behalf of such individual. I have read the provisions set forth in this authorization and agree that \_\_\_\_\_ may use and/or disclose the subject health information of such individual for the purposes set forth herein.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**Instructions for Completing this Form**

1. This form must be completed in its entirety in ink by the client (except if a minor, or incompetent or deceased) prior to the release or exchange of information.
2. This form must be signed by a parent or legal guardian of any client under age 18 or incompetent or deceased, or by a personal representative of the client.
3. If the purpose of this release is to authorize MABSSCO programs to release information to each other, this form is to be files in the appropriate clinical record of the client, with an indication of the specific information released. A copy of this release should be sent with the information.
4. If the purpose of this release is to authorize another facility to release information to MABSSCO. This form should be sent to that facility with a copy retained in the clinical record of the client.
5. If information is to be sought from more than one external facility, a separate, individualized "Authorization to Use/Disclose Health Information" form must be obtained for each external facility.

Revised 5/08



I understand that I will be provided with a copy of this signed authorization.

I deny the use or disclosure of my personal health information for the purpose(s) listed on this form.

I recognize that the Mid-American Baptist Social Service Corporation (MABSSCO) cannot guarantee the privacy of information released by it under this authorization, but it is my intent that the party I authorize to receive it will consider it private. I understand that information to be released by MABSSCO includes information received from other organizations or health providers if such information has been integrated into and made part of the records of MABSSCO according to its policies.

I acknowledge that release of the information constitutes waiver for the limited purpose designated herein of any therapist/client privilege or right to confidentiality that I may have under law.

|                  |  |         |
|------------------|--|---------|
| _____            | _____  | _____   |
| Client Signature | Personal Representative or Legal Guardian (if minor) | Witness |
| _____            | _____  | _____   |
| Print Name       | Print name   | Date    |
| _____            | _____  | _____   |
| Date             | Date   |         |

**If you are signing as a personal representative for an individual, read and sign below:**

I, \_\_\_\_\_, hereby certify and attest that I am the duly authorized personal representative of \_\_\_\_\_ and that I have the lawful authority to enter into this authorization on behalf of such individual. I have read the provisions set forth in this authorization and agree that \_\_\_\_\_ may use and/or disclose the subject health information of such individual for the purposes set forth herein.

\_\_\_\_\_

Signature

\_\_\_\_\_

Print Name

\_\_\_\_\_

Date

**Instructions for Completing this Form**

6. This form must be completed in its entirety in ink by the client (except if a minor, or incompetent or deceased) prior to the release or exchange of information.
7. This form must be signed by a parent or legal guardian of any client under age 18 or incompetent or deceased, or by a personal representative of the client.
8. If the purpose of this release is to authorize MABSSCO programs to release information to each other, this form is to be filed in the appropriate clinical record of the client, with an indication of the specific information released. A copy of this release should be sent with the information.
9. If the purpose of this release is to authorize another facility to release information to MABSSCO. This form should be sent to that facility with a copy retained in the clinical record of the client.
10. If information is to be sought from more than one external facility, a separate, individualized "Authorization to Use/Disclose Health Information" form must be obtained for each external facility.

**Research Authorization**

Your child will be receiving services through the Mid-American Baptist Social Service Corporation (MABSSCO). To help evaluate the effectiveness of our services, MABSSCO staff collect information about satisfaction with our services from youth, parents, referring agencies and others. This information is only used in aggregate form. We use the information to help us improve how we work with youth, parents and other stakeholders. Information that we may collect includes the following:

- **Client Satisfaction:** Satisfaction surveys are given to youth before discharge to evaluate their satisfaction with the program. We give or mail satisfaction surveys to parents and referring agents.
- **Information sharing with MCCCCA:** As a member of the Minnesota Council of Child Caring Agencies (MCCCCA), MABSSCO participates in a process of collecting data and evaluating its services. MCCCCA collects information in summary form that does not identify youth or families by name. Some of this information is shared with the State of Minnesota to assess the number and characteristics of children in Minnesota in out-of-home placements.
- **Administrative and Outcome data:** Staff will evaluate information collected about youth during their participation with a MABSSCO program.

**I hereby give research authorization.**

**I hereby deny research authorization.**

|                  |   |         |
|------------------|---|---------|
| Client Signature | Personal Representative/Parent or Guardian (if minor) | Witness |
| Print Name       | Print name  | Date    |
| Date             | Date  |         |

**If you are signing as a personal representative for an individual, read and sign below:**

I, \_\_\_\_\_, hereby certify and attest that I am the duly authorized personal representative of \_\_\_\_\_ and that I have the lawful authority to enter into this authorization on behalf of such individual.

|            |
|------------|
| Signature  |
| Print Name |
| Date       |

**Instructions for Completing this Form**

11. This form must be completed in its entirety in ink by the client (except if a minor, or incompetent or deceased) prior to the release or exchange of information.
12. This form must be signed by a parent or legal guardian of any client under age 18 or incompetent or deceased, or by a personal representative of the client.



MID-AMERICAN BAPTIST  
SOCIAL SERVICE CORPORATION

**Medical Authorization & Health Insurance Information**

In consideration of allowing \_\_\_\_\_ to reside in a MABSSCO facility, I/we hereby consent to and authorize MABSSCO to provide routine medical and dental care and emergency medical treatment MABSSCO staff may deem necessary on behalf of my child during the time my child is a resident of and under the supervision of a MABSSCO facility. I/we understand that medication will be given as directed and prescribed by a licensed physician or dentist and that I/we will be notified as soon as possible of any emergency medical treatment and/or medications given to my/our child.

Consent is hereby given for an exchange of medical and other information regarding my/our child between the doctor, clinic and other professionals and MABSSCO staff while he/she is in residence in a MABSSCO facility.

**Medical Insurance Information** *(please provide a copy of both sides of the insurance card):*

Medical Assistance (MA) Number (if applicable): \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

**Dental Insurance Information** *(please provide a copy of both sides of the insurance card):*

Insurance Company Name \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

|                  |                                  |            |
|------------------|----------------------------------|------------|
| _____            | _____                            | _____      |
| Client Signature | Parent/Legal Guardian (if minor) | Witness    |
| _____            | _____                            | _____      |
| Print Name       | Print Name                       | Print Name |
| _____            | _____                            | _____      |
| Date             | Date                             | Date       |

**Health Screen**

**Timeline: Must be completed within 24 hours of admission.** Review all information provided at admission and/or ask the child's parents and/or placing agency to help complete this screen.

Youth: \_\_\_\_\_ Date of Admit: \_\_\_\_\_ Date of Screen: \_\_\_\_\_

**Medical**

- Document the child's physical condition upon admission; include bruises, marks, rash and other signs of possible illness or injury:
  
- Current Medical problems and allergies:
  
- Current medications:
  
- History of and potential for self-injury:
  
- Primary Physician: \_\_\_\_\_ Date last seen by a physician: \_\_\_\_\_  
Clinic: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_
  
- Was the child's immunization record provided to MABSSCO?  Yes  No: \_\_\_\_\_

**Immediate Plan to Address Medical Needs:**

**Dental**

- Special dental needs?  No  Yes: \_\_\_\_\_
  
- Primary Dentist: \_\_\_\_\_ Date last seen by dentist: \_\_\_\_\_  
Clinic: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Immediate Plan to Address Dental Needs:**

**Other Healthcare Providers:**

- Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Date last seen: \_\_\_\_\_  
Clinic: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_
  
- Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Date last seen: \_\_\_\_\_  
Clinic: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
Signature of staff member who completed the screen \_\_\_\_\_  
Date

**Education Screen**

Youth: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Screen: \_\_\_\_\_

Is there a current Individual Education Plan (IEP) for this child? Yes No

Does the facility have a copy? Yes No

**If the facility does not have a copy of a current Individual Education Plan (IEP), complete the following information:**

Previous school attended:

Current School:

Current grade:

Special education needs:

How are the special education needs addressed?

\_\_\_\_\_  
Signature of staff member who completed the screen

\_\_\_\_\_  
Date

**Activity Authorization**

I/we grant permission for \_\_\_\_\_, to participate in activities such as recreational activities (including active sports), community service activities (including indoor or outdoor work), cultural and other learning or leisure activities while a resident of a MABSSCO facility.

In consideration for allowing my/our child to participate in these activities, I/we hereby release, forever discharge, and hold harmless, MABSSCO and its staff and other qualified persons from any and all claims, damages, injuries arising out of any accident, casualty or event as a result of \_\_\_\_\_ participating in these activities.

In addition, I/we authorize MABSSCO and its staff to obtain whatever medical treatment is necessary on behalf of said child for any injury arising out of any accident, casualty or event while said child is participating in activities while a resident of a MABSSCO facility.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Parent/Legal Guardian (if minor)

\_\_\_\_\_  
County Referring Agent (if under  
ct jurisdiction)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**Local Travel Authorization**

I/we agree to allow MABSSCO staff and other qualified persons to transport my/our child,  
 \_\_\_\_\_ in MABSSCO and private vehicles for the purpose  
 of providing care and treatment.

In consideration for allowing my/our child to participate in these trips, I/we hereby release, forever  
 discharge, and hold harmless, MABSSCO and its staff and other qualified persons from any and all  
 claims, damages, injuries arising out of any accident, casualty or event as a result of  
 \_\_\_\_\_ being transported in MABSSCO and private vehicles.

In addition, I/we authorize MABSSCO and its staff to obtain whatever medical treatment is necessary  
 on behalf of said child for any injury arising out of any accident, casualty or event while said child is  
 riding in the transporting vehicle.

|                  |                                  |   |
|------------------|----------------------------------|---|
| Client Signature | Parent/Legal Guardian (if minor) | County Referring Agent (if under<br>court jurisdiction) |
| Print Name       | Print Name                       | Print Name  |
| Date             | Date                             | Date  |

## Family Grievance Procedure

A MABSSCO resident's parent or legal representative, a guardian, or a concerned person in the resident's life may make a formal complaint or suggestion or express a concern about any aspect of the resident's care during the resident's stay in the facility. **The steps in the grievance process are as follows:**

1. Talk to a staff person, your child's assigned case coordinator and/or program director and try to resolve your complaint or grievance informally. If you are still unhappy you can go to step 2.
2. Put your complaint/grievance in writing. Give the written complaint/grievance to your child's assigned case coordinator or program director. Please write your complaint/grievance on a clean sheet of paper and include the following information:
  - a. Your name
  - b. The date you wrote the complaint/grievance
  - c. A description of your complaint/grievance with as much detail as you like and as needed to explain it.
  - d. A description of the action you would like the staff to take to resolve your complaint/grievance.
  - e. Sign and date your finished grievance.

We encourage you to follow these steps in order but you can submit a grievance beginning with step 1. or 2.

Any information about maltreatment of a child or vulnerable adult obtained through the grievance process will be reported as required by Minnesota Statutes, Section 626.556, Reporting of maltreatment to minors or Section 626.557, Reporting of maltreatment of vulnerable adults.

MABSSCO staff will respond to your grievance within five (5) days. Staff response may be appealed to MABSSCO's Chief Executive Officer at MABSSCO, PO Box 330, Victoria, MN 55386.

*Revised 5/08*

## Resident Basic Rights

One of our major goals in communicating information to you about resident's rights is to help assure that staff and residents are kept aware of the basic services and basic rights that are expected in any MABSSCO facility. We'll do our best to make sure you understand your rights while at MABSSCO. Please ask us if you have any questions.

While you are here we want you to feel respected and cared for. You have the right to basic services. "Basic services" means services to meet your basic need for food, shelter, clothing, medical and dental care, personal cleanliness, privacy, spiritual and religious practice, safety, and adult supervision.

You have other basic rights; including, but not limited to, the following rights:

1. The right to reasonable observance of cultural and ethnic practice and religion;
2. The right to a reasonable degree of privacy;
3. The right to participate in development of your treatment and case plan;
4. The right to positive and proactive adult guidance, support, and supervision;
5. The right to be free from abuse, neglect, inhumane treatment, and sexual exploitation;
6. The right to adequate medical care;
7. The right to nutritious and sufficient meals and sufficient clothing and housing;
8. The right to live in clean, safe surroundings;
9. The right to receive a public education;
10. The right to reasonable communication and visitation with adults outside the facility, which may include a parent, extended family members, siblings, a legal guardian, a caseworker, an attorney, a therapist, a physician, a religious advisor, and a case manager in accordance with your case plan;
11. The right to daily bathing or showering and reasonable use of materials, including culturally specific appropriate skin care and hair care products or any special assistance necessary to maintain an acceptable level of personal hygiene;
12. The right of access to protection and advocacy services, including the appropriate state-appointed ombudsman;
13. The right to retain and use a reasonable amount of personal property;
14. The right to courteous and respectful treatment;
15. If applicable, the rights stated in Minnesota Statutes, sections [144.651](#) and [253B.03](#);
16. The right to be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;
17. The right to be informed of and to use a grievance procedure; and
18. Right to be free from restraint other than to protect the resident from imminent danger to self or others.

### Resident Grievance Procedure

Any resident may file a grievance (a complaint or concern) or a compliment using the *Resident Grievance Procedure*. We will take your grievance seriously and respond to it right away.

**Please sign this form and keep a copy of the form. Your signature shows that we have informed you of your basic rights as a resident of a MABSSCO facility and that you understand them.**

\_\_\_\_\_  
*Client Signature*

\_\_\_\_\_  
*Parent/Legal Guardian (if minor)*

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Date*

## Rules of Conduct, Consequences & Restoration

| Rules of Conduct   | Consequences if Violated  | Restorative Tasks   |
|--|---|---|
| <p>1. <b>Respect Yourself</b><br/> Treat yourself with respect so that you stay safe, have good hygiene and are appropriately dressed for the weather and for a co-ed and respectful environment.<br/> <b>Why?</b> If you respect yourself, you will usually get more respect from others.</p>   | <ul style="list-style-type: none"> <li>• All privileges suspended until issue is addressed.</li> </ul>  | <ul style="list-style-type: none"> <li>• Work with others to decide how to make things as right as possible for all people negatively affected by your behavior.</li> <li>• Change into staff approved clothing.</li> <li>• Discontinue any unsafe behavior.</li> <li>• Address hygiene issues as requested.</li> </ul> |
| <p>2. <b>Respect Others</b><br/> Show respect, through words and actions, to others, including staff, other clients, family and other treatment team members and visitors, so that they feel valued and not harassed or intimidated for any reason, e.g., because of gender, race, beliefs, appearance, disability, culture or other difference. The same applies to behavior at school or in other public settings, or on MABSSCO sponsored activities<br/> <b>Why?</b> If you respect others, it will be easier for others to respect you.</p> | <ul style="list-style-type: none"> <li>• All privileges suspended until issue is addressed.</li> <li>• Stay separate from other clients as directed.</li> <li>• Stay within staff sight until dismissed from this level of supervision.</li> </ul>  | <ul style="list-style-type: none"> <li>• Work with others to decide how to make things as right as possible for all people negatively affected by your behavior.</li> </ul>   |
| <p>3. <b>Respect Property</b><br/> Respect and help maintain property through careful use of all of the facilities and equipment at MABSSCO Lodge.<br/> <b>Why?</b> It will be a safer, cleaner and better looking place for you.</p>  | <ul style="list-style-type: none"> <li>• All privileges suspended until issue is addressed.</li> <li>• Spend at least 15 minutes on an assigned cleanup/pickup task.</li> </ul>   | <ul style="list-style-type: none"> <li>• Work with others to decide how to make things as right as possible for all people negatively affected by your behavior.</li> <li>• Pay costs to repair or replace damaged property and/or assist in repair.</li> </ul>   |
| <p>4. <b>Support Others</b><br/> Be neutral or contribute positive, supportive messages to peers who are struggling with their own challenges. Do not support or give undue attention to disrespectful, disruptive or unsafe behavior. Stay away from situations that involve staff dealing with an emergency or highly charged situation.<br/> <b>Why?</b> If you support others, it's more likely that others will support you. It also helps make it a calmer and safer place for you to be.</p>  | <ul style="list-style-type: none"> <li>• All privileges suspended until issue is addressed.</li> <li>• Stay separate from other clients as directed.</li> </ul>   | <ul style="list-style-type: none"> <li>• Work with others to decide how to make things as right as possible for all people negatively affected by your behavior.</li> </ul>   |
| <p>5. <b>Stay in an Approved Location</b><br/> Stay in an approved location that is known and accessible to supervising adults. Do not leave without permission or attempt to conceal your whereabouts.<br/> <b>Why?</b> Stay in an approved location to increase your personal safety and to build trust.</p>   | <ul style="list-style-type: none"> <li>• All privileges suspended until issue is addressed.</li> <li>• Stay within staff sight until dismissed from this level of supervision.</li> </ul>   | <ul style="list-style-type: none"> <li>• Work with others to decide how to make things as right as possible for all people negatively affected by your behavior.</li> </ul>   |
| <p>6. <b>Promote Non-Violence and Peaceful Conflict Resolution</b><br/> Support an atmosphere that is free from violence or threats of violence. Use peaceful means of resolving disputes or conflicts. Do not have, or tolerate others having, any weapons or look-alike weapons.<br/> <b>Why?</b> If you are a peacemaker it will be safer and more relaxed for you and everyone else.</p>   | <ul style="list-style-type: none"> <li>• All privileges suspended until issue is addressed.</li> <li>• Stay within staff sight until dismissed from this level of supervision.</li> <li>• Write an essay of no less than 100 words about the positive impact of peacemaking or complete a "Thinking Report".</li> </ul> | <ul style="list-style-type: none"> <li>• Work with others to decide how to make things as right as possible for all people negatively affected by your behavior.</li> <li>• Demonstrate at least one instance of peaceful conflict resolution with another.</li> </ul>  |

| Rules of Conduct  | Consequences if Violated  | Restorative Tasks   |
|---|---|---|
| <p>7. <b>Support a Neutral Zone</b><br/>Welcome all youth as worthy of safety and support by not supporting, displaying or in any way recognizing that gang colors, symbols or gestures have any relevance in our setting.<br/><b>Why?</b> So you can relax and work on your goals with less distraction.</p>   | <ul style="list-style-type: none"> <li>All privileges suspended until issue is addressed.</li> <li>Write an essay of no less than 100 words about the positive impact of peacemaking or complete a "Thinking Report".</li> </ul>  | <ul style="list-style-type: none"> <li>Work with others to decide how to make things as right as possible for those negatively affected by your behavior.</li> <li>Remove or neutralize any gang related material.</li> </ul>   |
| <p>8. <b>Maintain Clean Air</b><br/>MABSSCO facilities and campuses are designated as smoke-free zones for all clients, staff, volunteers and visitors.<br/><b>Why?</b> So we can all breathe easier and promote a smoke-free lifestyle.</p>  | <ul style="list-style-type: none"> <li>Write an essay of no less than 100 words about the positive health affects of not smoking or complete a "Thinking Report".</li> <li>All privileges suspended until issue is addressed.</li> </ul>  | <ul style="list-style-type: none"> <li>Work with others to decide how to make things as right as possible for all people negatively affected by your behavior.</li> <li>Spend at least 15 minutes on an assigned cleanup/pickup task.</li> <li>Turn in cigarettes/lighters to staff.</li> </ul> |
| <p>9. <b>Maintain Chemical Health</b><br/>Residents will remain chemically-free while in residents except for use of medications as prescribed by a physician for their use or over-the-counter medications approved by a physicians order for a specific purpose.<br/><b>Why?</b> We want you to live a healthy life and hope you want that for yourself.</p>  | <ul style="list-style-type: none"> <li>All privileges suspended until issue is addressed.</li> <li>Stay within staff sight until dismissed from this level of supervision.</li> <li>Write an essay of no less than 100 words about alternatives to chemical misuse or abuse that might work for you or complete a "Thinking Report".</li> </ul> | <ul style="list-style-type: none"> <li>Work with others to decide how to make things as right as possible for all people negatively affected by your behavior.</li> </ul>   |
| <p>10. <b>Practice Healthy Boundaries</b><br/>Build positive, healthy relationships with peers, staff, volunteers and your community-based treatment team members to make progress on your placement critical and other treatment plan goals. Attempts to build relationships for other reasons are out of place at MABSSCO. The emotions, thinking and beliefs and physical boundaries of yourself and others are worthy of respect and understanding. Healthy touch is acceptable at MABSSCO. Touch that is viewed as sexualized, intrusive or harassing is not allowed. "Dating", physical or sexually based relationships are prohibited between clients and other clients and with staff, volunteers and visitors.<br/><b>Why?</b> So you can focus on yourself and your goals and feel respected while you do that.</p> | <ul style="list-style-type: none"> <li>Stay separate from other clients as directed.</li> <li>Stay within staff sight until dismissed from this level of supervision.</li> <li>All privileges suspended until issue is addressed.</li> </ul>  | <ul style="list-style-type: none"> <li>Work with others to decide how to make things as right as possible for all people negatively affected by your behavior.</li> </ul>   |
| <p>11. <b>Follow Directions</b><br/>Follow staff directions. They are intended to help make it a safe and respectful place for all.<br/><b>Why?</b> So you and others can be safe and feel respected</p>  | <ul style="list-style-type: none"> <li>All privileges suspended until issue is addressed and/or corrected.</li> </ul>   | <ul style="list-style-type: none"> <li>Work with others to decide how to make things as right as possible for all people negatively affected by your behavior.</li> </ul>   |

I have read, or have had read or explained to me, the above information about the Rules of Conduct, consequences for violating Rules of Conduct and the restorative tasks that are required if I violate the Rules of Conduct. I understand that MABSSCO staff and others will assist me in understanding and following these and other rules and expectations. I understand that I am accountable for any contribution I make to harm or disruption while a client of MABSSCO and that I am expected and required to make things as right as possible for all people negatively affected by my behavior.

\_\_\_\_\_  
Client/Resident Signature      Date      Parent/Guardian Signature      Date      MABSSCO Rep Signature      Date

## Understanding Rights, Privileges & Responsibility

### ***Rights***

**Rights are things you are entitled to. You don't have to earn them.** While you are here we want you to feel respected and cared for. You have the right to basic services throughout your stay. "Basic services" means services to meet your basic need for food, shelter, clothing, medical and dental care, personal cleanliness, privacy, spiritual and religious practice, safety, and adult supervision. See "Resident's Basic Rights" for a list and explanation of other basic rights.

### ***Privileges***

**Privileges are things that you earn. Depending on the reason you are placed, the amount and type of privileges you may earn, if any, and when you can earn them, will vary.** For example, if you are placed as a consequence for an incident or offense, then you will be limited to in-house scheduled activities or individualized schedule alternatives and will not be eligible to earn outside "fun" activities such as going to the movies. If you were placed for other reasons and have just arrived, then we need a period of time to get to know you before you can begin to earn privileges. You will also be busy completing the intake process and getting oriented to how we do things here. Here is a partial list of activities that are privileges while you are with MABSSCO:

***In-House/On-Campus Privileges Include:***

***Off-Campus Privileges Include:***

|  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Watching TV</li> <li>• Having a radio/CD player in your room</li> <li>• Watching DVD movies</li> <li>• Listening to music</li> <li>• Recreational reading</li> <li>• Playing table games</li> <li>• On-campus walks</li> <li>• Computer use</li> <li>• Smoking (designated outdoor areas only)</li> <li>• Cooking</li> <li>• Karaoke</li> </ul> | <ul style="list-style-type: none"> <li>• Going to a local community center for basketball, swimming, other sports and activities</li> <li>• Bowling</li> <li>• Roller skating</li> <li>• Seasonal activities (e.g., fishing, skiing, snowboarding, boating, hiking)</li> <li>• Concerts</li> <li>• Movies at the theater</li> <li>• Going to the library</li> <li>• Volunteering</li> </ul> |
|--|---|

### ***Responsibility***

**Responsibility is what we expect from you to earn or maintain privileges. Examples of being "responsible" include the following:**

- Follow the Rules of Conduct
- Accept the consequences and make amends if you violate a Rule of Conduct.
- Participate in required community service activities.
- Participate in restorative activities as needed or required.
- Work with a staff member to complete a daily review of your progress.
- Participate with your Community Treatment Team (CTT) in meetings and decision-making.

\_\_\_\_\_  
 Client/Resident Signature    Date                  Parent/Guardian Signature    Date                  MABSSCO Rep Signature    Date

## **Resident Grievance Procedure**

A young person residing in a MABSSCO facility may express complaints and grievances about the facility. **The steps in the grievance process are as follows:**

3. Talk to a staff person, your assigned case coordinator and/or program director and try to resolve your complaint or grievance informally. If you are still unhappy after this talk you can go to step 2.
4. Put your complaint/grievance in writing on a clean sheet of paper and include the following information:
  - a. Your name
  - b. The date you wrote the complaint/grievance
  - c. A description of your complaint/grievance with as much detail as you like and as needed to explain it.
  - d. A description of the action you would like the staff to take to resolve your complaint/grievance.
  - e. Sign and date your finished grievance.

Next, you can do either of the following things (or both) with your written complaint:

- Give it to your assigned case coordinator or program director and they will write back to you within 5 days.
- Send it to MABSSCO, P.O. Box 330, Victoria, MN 55386 ATTN: CEO

**We encourage you to follow these steps in order but you can submit a grievance beginning with either step 1. or 2.**

Residents, parents/guardians/custodians will be given a copy of this procedure upon request.

Any information about maltreatment of a child or vulnerable adult obtained through the grievance process will be reported as required by Minnesota Statutes, Section 626.556, Reporting of maltreatment to minors or Section 626.557, Reporting of maltreatment of vulnerable adults.



## Personal Property Policy

Upon arrival at a MABSSCO facility, all of your personal property will be inventoried using our *Personal Property Inventory* form. This inventory takes place at the time of admission in order to help assess your needs and protect all concerned regarding the care and protection of your property. MABSSCO staff will make every effort to work with you to keep your possessions safe and respectfully treated. MABSSCO is not responsible for personal items that are lost, damaged or stolen when they are not appropriately secured. MABSSCO discourages youth from bringing high value items with them.

When you purchase new items while at the program, they need to be placed on the inventory record. Some kind of proof of purchase is needed for new items.

Upon discharge from the program you will participate in an exit interview when all your possessions will be compared to your inventory record. All items that are not on your inventory record or otherwise accounted for will have to remain at the MABSSCO facility upon your discharge.

Trading, borrowing, buying, or selling items between residents is prohibited at any MABSSCO facility.

I, \_\_\_\_\_, understand this policy, how I can cooperate with it and agree to follow it.

Resident \_\_\_\_\_ Date \_\_\_\_\_

Resident Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

MABSSCO Staff Member \_\_\_\_\_ Date \_\_\_\_\_

**Personal Property Inventory**

Resident Name: \_\_\_\_\_ Date of Admission: \_\_\_\_\_

Initial Inventory completed by: \_\_\_\_\_ Program: \_\_\_\_\_

I \_\_\_\_do \_\_\_\_do not have money or other valuables in my possession.

If you have money, how much? \$\_\_\_\_\_

Staff will give you a receipt for the money if you would like it locked in a secure area.

Describe other valuables:

| Item | Description | Quantity | Secured by staff? |
|------|-------------|----------|-------------------|
|      |             |          |                   |
|      |             |          |                   |
|      |             |          |                   |
|      |             |          |                   |
|      |             |          |                   |

**Clothing Inventory & Standards List and other Items**

| Item        | Standard # | Description/Size | Updates |
|-------------|------------|------------------|---------|
| Socks       | 7          |                  |         |
| Underwear   | 7          |                  |         |
| Shirts/Tops | 7          |                  |         |

|                          |   |  |  |
|--------------------------|---|--|--|
| Jeans/pants              | 5 |  |  |
| Sweatshirts/<br>sweaters | 3 |  |  |
| Shorts                   | 3 |  |  |
| Sleepwear                | 2 |  |  |

| <b>Item</b>        | <b>Standard #</b> | <b>Actual # (Fit &amp; in good condition)</b> | <b>Updates</b> |
|--------------------|-------------------|---|----------------|
| Shoes<br>(pairs)   | 2                 |   |                |
| Slippers           | 1                 |   |                |
| Swimwear           | 1                 |   |                |
| Belt               | 1                 |   |                |
| Winter coat        | 1                 |   |                |
| Winter hat         | 1                 |   |                |
| Winter<br>boots    | 1                 |   |                |
| Gloves/<br>mittens | 2                 |   |                |

|                              |                    |  |               |
|------------------------------|--------------------|--|---------------|
| Spring/Fall jacket           | 1                  |  |               |
| Outfit for special occasions | 1                  |  |               |
| Bathrobe                     | 1                  |  |               |
| Shower shoes                 | 1                  |  |               |
| Sweat pants                  | 1                  |  |               |
| Gym shorts                   | 1                  |  |               |
| <b>Other Items</b>           | <b>Description</b> |  | <b>Update</b> |
|                              |                    |  |               |
|                              |                    |  |               |
|                              |                    |  |               |
|                              |                    |  |               |
|                              |                    |  |               |
|                              |                    |  |               |

| <b>Item</b> | <b>Description</b> | <b>Update</b> |
|-------------|--------------------|---------------|
|             |                    |               |
|             |                    |               |
|             |                    |               |
|             |                    |               |



## Checklist of Approved Screenings for all Child Residential Settings

Child \_\_\_\_\_ Age \_\_\_\_\_  
Facility \_\_\_\_\_ Date \_\_\_\_\_

This checklist documents the requirements found in Minnesota Rules, section 2960.0070, subdivision 5. Programs with transitional services certification are exempt from this requirement.

Screenings must be completed by trained staff. It is not necessary to repeat the screen if a recent screen or assessment (180 days) has been completed and is part of the documentations received by the facility. Use the results of the screening to determine the identified needs and plan further assessment and services. Work with the placing agency and parents to develop a plan to address the child's needs, as appropriate.

### Health Screen

Timeline: Within 24 hours of admission.

For all children and youth

\_\_\_\_ Completed Health Screen.

Completed by: \_\_\_\_\_ Date completed \_\_\_\_\_

### Education Screen

Timeline: Within 24 hours of admission. For all children and youth \_\_\_\_ Completed Education Screen or \_\_\_\_ Received a copy of the child's/youth's IEP Completed by:

\_\_\_\_\_ Date completed \_\_\_\_\_

### Vulnerability Assessment and Sexual Abusive Behavior Screen

Timeline: Required for detention facilities in MN Rules 2960.0260, subpart 3 at admission. All other facilities must begin the screen within 3 working days and complete within 6 working days of admission. For all children and youth \_\_\_\_ Completed Completed by:

\_\_\_\_\_ Date completed \_\_\_\_\_

### Mental Health Screen

Timeline: Must begin the screen within 3 working days and complete within 6 working days of admission.

*For children ages 12 and over*

\_\_\_\_ Completed POSIT or MAYSI 2 screening tool, or

\_\_\_\_ Received a copy of a diagnostic assessment completed by a licensed mental health professional within 180 days prior to admission.

Completed by: \_\_\_\_\_ Date completed \_\_\_\_\_

*For children younger than 12 at admission*

\_\_\_\_ Completed Pediatric Symptom Checklist (PSC), or

\_\_\_\_ Received a copy of a diagnostic assessment completed within 180 days prior to admission

by a licensed mental health professional.

Completed by: \_\_\_\_\_ Date completed \_\_\_\_\_

**Chemical Abuse Screen**

Timeline: Must begin the screen within 3 working days and complete within 6 working days of admission.

\_\_\_\_ Completed POSIT or MAYSI 2 screening tool, or

\_\_\_\_ Received a copy of a chemical health assessment completed by a licensed chemical health professional prior to admission.

Completed by: \_\_\_\_\_ Date completed \_\_\_\_\_

**Cultural Screen**

Timeline: Must begin the screen within 3 working days and complete within 6 working days of admission. For all children and youth \_\_\_\_ Completed the Minnesota Department of Human

Services Culture Screen/Interview Completed by: \_\_\_\_\_ Date completed

\_\_\_\_\_

**Gender Specific Needs Screen**

Timeline: Must begin the screen within 3 working days and complete within 6 working days of admission. For all children and youth \_\_\_\_ Completed Minnesota Department of Human Services

Observation Tool Completed by: \_\_\_\_\_ Date completed \_\_\_\_\_

**Resident's Family**

Document the inquiries and the results of the inquiries regarding the degree to which the resident's family desires to be involved during the resident's stay at the facility.

CC: Parent (unless not allowed by court order)  
Placing Agency