GREAT PLAINS AREA YOUTH REGIONAL TREATMENT CENTER

(GPAYRTC)

12451 HWY 1806 N
P.O. Box 680
Mobridge, SD 57601

Tel: 605-845-7181
FAX: 605-845-5072

APPLICATION For ADMISSION

MISSION STATEMENT

The *Great Plains Area Youth Regional Treatment Center is dedicated to providing a safe, compassionate, healing environment where our American Indian youth can be strengthened socially, spiritually, emotionally and physically utilizing a holistic, multi-disciplinary approach.*

VISION STATEMENT

The Great Plains Area Youth Regional Treatment Center is dedicated to promoting a healthy lifestyle restoring balance and harmony in mind, body & spirit to our American Indian youth and their families

IMPORTANT INFORMATION FOR PARENTS/GUARDIANS AND BEHAVIORAL HEALTH PROVIDERS

- We recommend that this Application for Admission be completed by a health care professional.

- Completed Packet shall be transmitted via FAX to: Attn: Admission Coordinator; 605-845-5072, and CALL 605-845-7181 to confirm transmission.

- Residents shall only be discharged to a legal guardian or property authorities.

PHILOSOPHY

We believe substance abuse and dependency can be successfully treated in a safe environment. Substance abuse is a disease that impacts the individual, the family, and the entire community. The Great Plains Area Youth Regional Treatment Center blends American Indian/Alaska Native tradition and current therapeutic techniques in a holistic multidisciplinary team approach to successfully provide recovery services. Individuals are treated with dignity and respect in an environment that honors positive personal beliefs.

Historical grief has affected nearly all American Indians/Alaska Natives. We believe our clients have the right to be treated with dignity and respect. All residents will have access to needed services to achieve optimal outcomes. All residents will be empowered to exercise informal choices about their Substance Abuse Treatment.

Our treatment program will facilitate this process by a variety of group processes: the effects of chemicals on the whole person and enhance ethnic identity. Staff members work with home-area service provide follow-up and coordinate aftercare resources and facilitate on-site family education and therapy.

Our philosophy also includes self-examination for all staff members. Our staff regularly evaluates their professional strengths, limitations, biases and levels of effectiveness. We strive for self-improvement and seek professional development and personal growth to promote effective treatment outcomes. Our mandate is to provide the highest quality care and to promote healthy lifestyles among Native American adolescents.

12-Step Programs, such as the 12 Steps of Alcoholics Anonymous, Narcotics Anonymous and all the related groups provide a significant theme that is incorporated throughout the treatment services provided at Great Plains Area Youth Regional Treatment Center. Residents are transported to AA meetings off-site at least once per week.

Admission Criteria

All criteria must be met before an admission can occur.

- Eligible for direct care from the Indian Health Service.
- Member of a federally recognized tribe, proof of pending enrollment or proof of tribal lineage (documentation required).
- Age range; 13-17. Applicants that are 18 years of age are handled on a case-by-case basis.
- The applicant's primary DSM V, or ICD-10 diagnosis recorded on a drug and alcohol assessment is of substance abuse or dependence.
    - Note that if the other disorders are superseding and interfering with substance abuse treatment, the applicant will likely not be admitted.
- A bio-psychosocial assessment has been performed within the last six months, and indicates the applicant's symptoms and life situation meet the American Society of Addiction Medicine's Patient Placement (ASAM PPC-2R) admission criteria. Unless otherwise indicated by recent incidents such as psychiatric hospitalizations.
- Detoxification, if necessary, will be conducted at local facilities before the applicant enters treatment.
- Readmission criteria will fall under the same guidelines. Readmission will be considered based on previous progress in treatment, and anticipated ability to fit into program structure.

The following conditions may exclude admission to the Great Plains Area Youth Regional Treatment Center.

- The potential resident's Primary DSM V, or ICD-10 diagnosis is anything other than a substance abuse or dependence diagnosis.
- The potential resident refuses to participate in the treatment program.
- The applicant has active suicidal ideation or a recent history of suicide attempt or self-injury.
- Active homicidal ideation, or the potential resident has a recent history of aggressive behavior or violence.
- Active psychosis or an unresolved impairment in reality testing is present in the potential resident.
- The potential resident has medical conditions that cannot be managed without 24-hour medical care.
- The level of cognitive skills or development is such that the potential resident will be unable to participate in treatment.
- The potential resident is unable to perform ordinary daily living tasks.
- The potential resident has a history of behaviors that would significantly interfere with other residents' treatment.
- A history of sexual predation or assault excludes the potential resident from admission.

Referrals for Admission

Purpose:
To clearly define the procedures to be followed in processing applications for admission to GPAYRTC.

Policy:
The GPAYRTC receives applications for admission from families and agencies across the United States. Agencies include, but are not limited to, outpatient programs, mental health programs, courts: both tribal and state, including probation, and other correctional officers. All admissions are scheduled based on available bed space. Admissions are scheduled for approved applicants in consideration of the date the application was determined "complete" for screening purposes. The earliest complete screening application received will be scheduled first.

The GPAYRTC's Admissions Committee determines approval of admission. Consideration for admission is established by GPAYRTC, IHS, and DHHS policy and procedures.

The Admissions Committee is composed of the following:
Clinical Director
Supervisory Substance Abuse Therapist
Mental Health Therapist
Family Therapist/Social Worker
Nurse
Education Specialist
Administrative Officer

***Three (3) voting members constitutes a Quorum. ***

Admissions meetings are held weekly and as needed.

Procedure:

Initial application is received and screened to ensure the following documents are in the application:

A. Form: TC-AD-2: Residential Application
B. Bio. Psycho Social Assessment: Within six (6) months
    1. Primary Diagnosis must be Chemical Dependency
C. Release of Information (ROI): 10 Total -Go to the IHS HIPAA FORMS link on our website for the latest IHS-810(ROI) – see **sample** ROI's in the Admissions Packet for an example of what is needed
    Information on applicants CANNOT be obtained without a completed ROI*
D. Form TC-AD-3: History & Physical within the last three (3) Months
E. Labs: Within the last 60 days
    a. UA
    b. HCG (Within 10 days)
    c. STD Screen:
        i. Gonorrhea
        ii. Chlamydia
        iii. Syphilis
        iv. HIV
        v. Hepatitis Panel
F. Immunization Records

G. Record of negative PPD results in the last 12 month, via Tuberculin Skin Test, TB Blood Test, Chest X-ray, or other form of medical documentation
    a. if a Positive PPD is recorded, the applicant will need clearance from the State to enter treatment at the GPAYRTC
H. Copies of:
    a. Social Security Card
    b. Birth Certificate
    c. Tribal Enrollment
    d. Insurance Card
I. Court Order: If applicable
J. School Records:
    a. IEP: If applicable
    b. Transcripts
K. Previous Discharge Summaries: If applicable
L. Medical Support Assistant will track admission documents on the, "Intake Checklist"

Packets considered complete shall be distributed to the Admission Committee for review.

A. Complete packets shall consist of items A thru K listed above

The Admission Committee shall have seven (7) calendar days to complete their review, and note their findings on the Admission Committee Review form.

A. If additional information is needed, the reviewing committee member will consult with the referral source.
B. The Clinical Director, or his/her designee will complete the bottom portion of the Admission Committee review form
C. The complete, reviewed, packet will be presented at the next scheduled Admission Meeting

The Admission Committee will make one of the following decisions:

A. Approved
B. Denied
C. Placed on waiting list
    a. Waiting lists may occur due to vacancy and/or staffing.
    b. Recommend applicant be placed in another facility.
    c. Recommendations will be made both orally and in writing by the Clinical Director or his/her designee.

A letter will be drafted regarding the Admission Committee's decision.

A. The Letter will be reviewed/signed by the Clinical Director or his/her designee.
B. Admission Committee member will fax Admission/Denial letter to referent agency.
C. The Admissions Coordinator will file a letter that documents the Committees final decision in patient chart, an electronic version will be shared on hard drive.

Please fax all documents associated with the admission packet to:

Attn:

Admission Coordinator Fax: 605-845-5072

ADMISSION CHECKLIST

Great Plains Area Youth Regional Treatment Center

1. The Chief Gall Great Plains Area Youth Residential Treatment Center is funded and operated by the Department of Health and Human Services, Indian Health Services. For admission to the GPAYRTC an applicant/referral ***MUST*** provide the following required documents:

		Completed		Date Completed
a.	☐ Completed Residential Application Form.	☐ Yes	☐ No	
b.	☐ A Bio-psycho-social Assessment, completed by a duly State licensed professional within the last six months. It must contain a primary diagnosis of Substance Abuse/Dependence.	☐ Yes	☐ No	
c.	Physical History and Examination by a Physician, NP, or PA to include: ☐ History of allergies ☐ Dental exam ☐ All Labs Completed ☐ Physical limitations ☐ Medication orders ☐ Eye Exam	☐ Yes	☐ No	
d.	☐ Proof of TB test results with in the last year.	☐ Yes	☐ No	
e.	☐ Immunization Record	☐ Yes	☐ No	
f.	☐ School Records	☐ Yes	☐ No	
g.	☐ Releases of Information, IHS-810 form. A total of eight IHS-810 forms are enclosed. All need to be signed as indicated in item II (Legal Guardian, Client, referent, school and medical facility). Please complete the form by checking the box that pertains to each form.	☐ Yes	☐ No	
h.	☐ Copy of Birth Certificate.	☐ Yes	☐ No	
i.	☐ Copy of Social Security Card.	☐ Yes	☐ No	
j.	☐ Copy of Degree of Indian Blood	☐ Yes	☐ No	
k.	☐ Copy of Medicaid or Private Insurance coverage (If applicable)	☐ Yes	☐ No	
l.	☐ Legal Custody Order (if applicable)	☐ Yes	☐ No	
m.	☐ Court Order (if applicable)	☐ Yes	☐ No	

1. After all required items have been received; the Admissions committee will make a final decision.
2. Once a final decision for admission is made, an admission acceptance letter will be submitted (faxed or mailed) to the referring agency.
3. The GPAYRTC is prohibited from accepting any applicants without the explicit written approval (an admission acceptance letter) of the admission committee and with concurrence by the Clinical Director.

Applicant Information

Name:			**Date:**
Address:		**City, State & Zip Code:**	
Date of Birth:	**Age:**	Sex: ☐ Female ☐ Male	**Social Security #:** — —
Home Phone #:		**Religion:**	
Tribal Affiliation:			

Parent/Guardian

Mother's Name:	
Address:	**City, State & Zip Code:**
Home Phone #:	**Work Phone #:**
Date of Birth:	**Tribal Affiliation:**
Father's Name:	
Address:	**City, State & Zip Code:**
Home Phone #:	**Work Phone #:**
Date of Birth:	**Tribal Affiliation:**

Emergency Contact

Name:	**Relationship to Client:**
Address:	**City, State & Zip Code:**
Phone #:	**Work Phone #:**

Referral Source

Name:	**Relationship to Client:**
Address:	**City, State & Zip Code:**
Phone #:	**Work Phone #:**

Health Care Coverage

IHS Service Unit:			**Phone #:**
Eligible for Contract Health Services? ☐ **Yes** ☐ **No**	Name & Phone # of IHS/ CHS Authorizing Official:		
Medicaid(welfare)? ☐ **Yes** ☐ **No**	**Medicaid #:**	**State Medicaid filed in:**	**Eligibility Date:**
Private Insurance? ☐ **Yes** ☐ **No**	**Insurance #:**	**Name of Insured:**	
Relationship to Client:		**Name of Insurance Company:**	
Address:		**City, State & Zip Code:**	
Phone:		**Fax:**	
Reason for referral?			

Emotional/Behavioral Conditions and Complications

Has the client seen a psychiatrist, psychologist, or counselor for emotional or mental problems? ☐Yes ☐No	**If "YES" please explain:** **Therapist's Name** **Phone #** **Dates of Treatment** **Reason for Therapy**	
Is the client currently in outpatient treatment? ☐Yes ☐No	If "YES" describe frequency and regularity of visits:	
Does the client have a history of suicide thoughts or attempts? ☐Yes ☐No	If "YES" please describe the situation(s) to include how and with what they tried to harm themselves:	
Was the client Hospitalized? (If yes, provide discharge summary) ☐Yes ☐No	Date Methods Name of Hospital # Days in Hosp. Substance Abuse Involved?	
Does the potential resident currently have any suicidal thoughts ☐Yes ☐No	**If "YES" please describe:**	
Does the potential resident currently have any homicidal thoughts? ☐Yes ☐No	**If "YES" please describe:**	
Does the client have past or current legal problems? ☐Yes ☐No	If "YES" please describe:	
Does the client have a history of violent or assaultive behavior? ☐Yes ☐No	**If "YES" please describe:**	
Has the client been involved with a gang? ☐Yes ☐No	If "YES" which gang and what are their colors?	**Describe the client's involvement with the gang:**

Residential Admission Form
GPAYRTC
Substance Use History

Is the client court ordered to treatment? ☐Yes ☐No	**If "YES" please enclose a copy of the court order.**
Does the client have any symptoms of an eating disorder? These may be restricted food intake, excessive exercise, use of laxatives, binge eating or vomiting. ☐Yes ☐No	**If "YES" please explain:**
Does the client have a history of fire setting? ☐Yes ☐No	**If "YES" please describe:**
Does the client have a history of problematic sexual behavior? ☐Yes ☐No	**If "YES" please describe:**

Does the client have a history of learning problems learning disability, special education, resource rooms, and mental retardation? ☐ Yes ☐ No	**If "YES" please describe:**

Is the client pregnant? ☐ Yes ☐ No	If "YES" how many weeks pregnant?	Prenatal care provider name, location and phone #:	When was the last prenatal appointment?

Does the adolescent recognize their use of drugs and/or alcohol is a problem? ☐ Yes ☐ No	Please describe:
How does the adolescent describe his/her use of drugs and/or alcohol?	Please describe:

Is the client having any drug cravings or demonstrating any drug-seeking behavior? ☐ Yes ☐ No	Has their drug and/or alcohol use increased recently? ☐ Yes ☐ No	If "YES" please describe:
Has the client made attempts to control or cut down on their substance use? ☐ Yes ☐ No	If "YES" please describe:	
If the client is abstinent, are they in a personal crisis and at risk of relapse? ☐ Yes ☐ No	**If "YES" please describe:**	

The following questions deal with whether the client's current environment is not supportive of recovery, is hazardous, or there are difficulties in the home that make it difficult to participate in treatment on an outpatient level.

	Family Member's Name	**Age**	**Relationship**
Please list the members of the client's family.			

Who currently lives in the home with the client, other than family members? Please list their names, ages, and relationship to the client.	Name	Age	Relationship

Is there any history of violence or domestic abuse in the home? ☐Yes ☐No	**If "YES" please describe:**
Is there anyone currently living in the client's home that is an active substance abuser? ☐Yes ☐No	**If "YES" please describe:**
Is there anyone currently living in the client's home that is active in a recovery program? ☐Yes ☐No	**If "YES" please describe:**
Does the client have any friends who are Non-users or are active in a recovery program? ☐Yes ☐No	If "YES" please check which program: ☐Aftercare ☐Alateen ☐AA ☐NA ☐Al-Anon ☐Other If "Other", please describe:
What types of support groups are available to the family?	☐Aftercare ☐Alateen ☐AA ☐NA ☐Al-Anon ☐Healing Through Feeling ☐Other If "Other" please describe:

Substance (Check all that apply)	Age of First Use	Date of Last Use	Usual Amount Used	Frequency of Use	Months or Years of Actual Use	How Taken (See Below)	Tolerance (Yes or No)	Withdrawal (Yes or No)
Alcohol:								
Beer/Coolers ☐								
Wine ☐								
Hard liquor ☐								
Cannabis:								
Marijuana ☐								
Hashish ☐								
Hash Oil ☐								
Hallucinogens:								
LSD or "Acid" ☐								
Peyote/Mescaline ☐								
Psilocybin ☐								
PCP ☐								
Mushrooms ☐								
Datura ☐								
Other ☐								

Cocaine:								
Powder ☐								
Crack/Freebase ☐								
Opiates ☐								
Heroin ☐								
Codeine ☐								
Opium ☐								
Synthetics ☐								
Stimulants:								
Speed ☐								
Crank/Crystal ☐								
Ice ☐								
STP, MDA,. etc. ☐								
Sedatives:								
Valium ☐								
Librium ☐								
Xanax ☐								
Nicotine:								
Cigarettes ☐								
Cigars ☐								
Pipes ☐								
Chew Snuff ☐								
Snort Snuff ☐								
Inhalants:								
Solvents ☐								
White-out ☐								
Spray Cans ☐								
Anesthetics ☐								

How Taken: **O** =Oral **I**= Injection **X**= Other

Frequency of Use: (Chose a number that best describes the frequency of use)

1 = No use in the past month. **2** = Once a month **3** = Once a week

4= 2- 3 times per week **5** = Once a day **6**= 2-3timesaday **7=** Continuous Use

Referral Source			
Program Name:			
Address:	**City:**	**State:**	**Zip:**
	Phone:	**FAX:**	
	E-MAIL:		
Name: (Print)	**Signature:**	**Date:**	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

Criminal Justice System Release of Information

I, _____, hereby voluntarily authorize the disclosure of my substance abuse treatment records (Name of Patient)

The substance abuse treatment information is to be disclosed by: Name of Facility/Organization	And is to be provided to: Name of Facility/Organization
Great Plains Area Youth Regional Treatment Center	_____
Address	Address
PO Box 680	_____
City/State	City/State
Mobridge, SD 57601	_____

The purpose of this disclosure is: (Initial)

_____ Further Medical Care _____Attorney _____After Care _____Research

_____ Personal Use _____Insurance _____Disability

_____ Other: (Specify _____Verification of Presence & Progress in Treatment

The substance abuse treatment record information to be disclosed is: (Initial)

_____ Only information related to: Continued presence and progress in treatment

_____ Only the period of events from: _____

_____ Other (specify) CHS, Billing, etc.: _____

_____ Intake Assessment's: _____

_____ Discharge Summary: _____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: (Initial)

When there has been a formal and effective termination or revocation of my release from confinement, probation, parole, or _____ other proceeding under which I was mandated into treatment or:

I understand that I might be denied services if I refuse to consent to a disclosure to the Criminal Justice System that mandated my presence in treatment. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.
Dated: _____ Patient Signature: _____

Signature of person signing form if not the _____patient:

_____
(Describe authority to sign on behalf of patient)

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

CLIENT NAME FOR INTERVIEW

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 09-30-2023
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

II. The information is to be disclosed by: Referring Agency	**And is to be provided to: GPAYRTC**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY **GREAT PLAINS AREA YOUTH REGIONAL TREATMENT CENTER**
ADDRESS	ADDRESS **PO BOX 680**
CITY/STATE	CITY/STATE **MOBRIDGE, SD 57601**

III. The purpose or need for this disclosure is:

[X] Further Medical Care [ ] Attorney [ ] School [ ] Research [ ] Other *(Specify)* _____
[ ] Personal Use [ ] Insurance [ ] Disability [ ] Health Information Exchange (IHS/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

[X] Only information related to *(specify)* _____

[ ] Only the period of events from _____ to _____
[ ] Other *(specify) (CHS, Billing, etc.)* _____
[ ] Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

[X] Alcohol/Drug Abuse Treatment/Referral [ ] HIV/AIDS-related Treatment
[ ] Sexually Transmitted Diseases [X] Mental Health *(Other than Psychotherapy Notes)*
[ ] Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated. For Health Information Exchange authorizations, it is recommended to expire in at least three years.

_____
(Specify new date)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by: **GPAYRTC**	And is to be provided to: **Referring Agency**
NAME OF FACILITY **Great Plains Area Youth Regional Treatment Center**	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS **12451 Hwy 1806 PO Box 680**	ADDRESS
CITY/STATE **Mobridge, SD 57601**	CITY/STATE

III. The purpose or need for this disclosure is:

☑ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* _____

☐ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (IHS/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

_____

☐ Only the period of events from _____ to _____

☐ Other *(specify) (CHS, Billing, etc.)* _____

☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☑ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment

☐ Sexually Transmitted Diseases ☑ Mental Health *(Other than Psychotherapy Notes)*

☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years.

_____
(Specify new date)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

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PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by: **Parents/Legal Guardians**	And is to be provided to: **GPAYRTC**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY **Great Plains Area Youth Regional Treatment Center**
ADDRESS	ADDRESS **12451 Hwy 1805/PO Box 680**
CITY/STATE	CITY/STATE **Mobridge, SD 57601**

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* _____

☑ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (IHS/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

_____

☐ Only the period of events from _____ to _____

☐ Other *(specify) (CHS, Billing, etc.)* _____

☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment

☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*

☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. Alcohol/Drug Abuse Treatment/Referral

_____

(Specify new date)

I understand that IHS will not condition treatment or eligibility or care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

NAME *(Last, First, MI)*

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

RECORD NUMBER

ADDRESS

CITY/STATE

DATE OF BIRTH

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by: **GPAYRTC**	And is to be provided to: **Parents/Legal Guardians**
NAME OF FACILITY **Great Plains Area Youth Regional Treatment Center**	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS **12451 Hwy 1806/ PO Box 680**	ADDRESS
CITY/STATE **Mobridge, SD 57601**	CITY/STATE

III. The purpose or need for this disclosure is:

☑ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* _____

☑ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (IHS/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

_____

☐ Only the period of events from _____ to _____

☐ Other *(specify) (CHS, Billing, etc.)* _____

☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment

☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*

☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. Alcohol/Drug Abuse Treatment/Referral

_____

(Specify new date)

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SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by: **School of Record**	**And is to be provided to: GPAYRTC**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY **Great Plains Area Youth Regional Treatment Center**
ADDRESS	ADDRESS **12451 Hwy 1806 / PO Box 680**
CITY/STATE	CITY/STATE **Mobridge, SD 57601**

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☑ School ☐ Research ☐ Other *(Specify)* _____

☐ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (IHS/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

_____

☐ Only the period of events from _____ to _____

☐ Other *(specify) (CHS, Billing, etc.)* _____

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NAME *(Last, First, MI)*	RECORD NUMBER
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GPAYRTC

This form is to be completed by a licensed Physician, Physician's Assistant, or a Nurse Practitioner. A complete history and physical examination **needs to be completed within at least 60 days** prior to entering our treatment facility.

Client's Name: _____ Date of Physical: _____

DOB: _____ ☐Male ☐Female (check one)

VITAL SIGNS: T_____ P_____ R_____ B/P_____ HT_____ WT_____ (HT/WT without shoes)

ALLERGIES: ☐Yes ☐No (Check all that apply and explain reaction)	☐Medications ☐Food ☐Bee Stings ☐Others

VISION Screening: R_____ L_____ Corrected_____ Uncorrected_____

HEARING Screening: R_____ L_____ Corrected_____ Uncorrected_____

REPRODUCTIVE FACTORS: (Check one) ☐G ☐P ☐LC ☐SA ☐TZ	LMP:	Smoking: ☐Yes ☐No PPD_____ Chewing Tobacco: ☐Yes ☐No

CURRENT MEDICAL PROBLEMS:

_____

Current Medications and Dose:

_____

DRUG/ALCOHOL Usage History: (Circle all that apply)	Alcohol	Marijuana	Inhalants	Prescriptions Drugs	Others:_____
How Long:					
Last Use:					
Other Street Drugs:					

LABS REQUIRED: ☐UA ☐HCG ☐STD Screen (HIV, Syphilis, Gonorrhea, Chlamydia)

(BY GPAYRTC) ☐Hepatitis Panel (with A, B, C) — **Please Attach Copies of ALL LABS**

Yes	No	History	Appearance	NL	ABN	Appearance	NL	ABN
		Heart Disease	Throat			Mouth		
		Heart Murmur	Skin			Genitalia		
		Hypertension	Eyes			Spine/Scoliosis		
		Diabetes	Ears			Rectal		
		Tuberculosis	Nose			Pelvic		
		Surgeries	Abdomen			Breast		
		Any Prosthesis	Extremities			Heart		

Yes	No	History	Appearance	NL	ABN	Appearance	NL	ABN
		Asthma	Neuro			Psychological		
		Seizures	Musculoskeletal			Endo/Meta		
		Cancer	Blood/Lymph			Neuro.		
		Hepatitis	Cardio.					
		STD's	Respiratory					
		Kidney Disease	GI/Liver					
		Athlete's Foot	Kidney/ Urol					
		Mental Disorders	Genitalia					
		Hospitalization	Breasts					
			Gyn					
			Neck					

Diagnosis:

Plan:

Physical restrictions: (If Applicable)

(Note: Approximate length of stay at GPAYRTC ***may exceed*** three (3) months or longer. Please schedule any ***CRITICAL*** appointments ***before*** admission to the facility.)

*****PLEASE ATTACH THE PPD FORM AND A COPY OF THE IMMUNIZATION RECORD*****

Medical Provider			
Hospital Name:			
Address:	**City:**	**State:**	**Zip:**
	Phone:	**FAX:**	
	E-MAIL:		
Name: (Print)	**Signature:**	**Date:**	

TUBERCULIN SKIN TEST QUESTIONNAIRE
GPAYRTC

Client's Name: _____ SSN#_____-_____-_____ DOB:_____

Please answer the following questions about your health prior to your TB skin test. "Yes" answers indicate conditions that can cause false results on the TB test.

a. Have you ever had Tuberculosis or a positive TB skin-test?.. ☐Yes ☐No

—If yes, were you treated?..... ☐Yes ☐No

—If yes, have you had a recent chest x-ray?..... ☐Yes ☐No

✓ (If you have answered ***Yes*** to the above questions, please attach documentation Recording a ***Negative*** PPD result via Tuberculin Skin Test, TB Blood Test, and or, a chest X-ray.)

---

b. Are you pregnant?..... ☐Yes ☐No ☐N/A

c. Are you currently ill or running a fever?..... ☐Yes ☐No

d. Have you received a vaccine in the last two months?..... ☐Yes ☐No
(i.e. MMR, flu vaccine, etc.)

e. Have you had a viral infection within the last two months?..... ☐Yes ☐No

TUBERCULIN SKIN TEST DATA

***Please note that results for a TB skin test done within the last year are acceptable, if all the information requested below is available on that test result.

1. TB skin test given on: _____ _____ on ☐Right — ☐Left forearm
Date Time (Check one)

Given by: _____ _____
Nurse's Name and Signature Phone No.

TB Skin Test Must Be Read Within 48 - 72 Hours of Placement on The Forearm
Tests Not Read and Recorded Within This Time Will Be Considered Invalid.

2. Skin test read on: _____ _____. Results in mm's: _____
Date Time

3. Redness?..... ☐Yes ☐No Induration?..... ☐Yes ☐No

*—If induration noted; size in mm's*_____

Read by: _____ _____
Nurse's Name and Signature Phone No.

CLOTHING/HYGIENE CHECKLIST

GPAYRTC

Clothing:

Residents will be provided with necessary clothing (T-shirts, Shorts, Sweatpants, and Sweatshirts) while admitted to the GPAYRTC.

Upon admission, all personal belongings will be inventoried, and stored in a secure room until discharge.

It is recommended that residents bring only clothing that will be worn at admission/discharge.

Absolutely NO gang colors or lettering: No alcohol/drug/gambling-related logos on any clothing.

	Necessary:		***Seasonal:***
	5-7 Under Shirts or Tank tops (T-Shirts)		***Gloves***
	5-7 Pairs of socks		***Stocking Hat/Beanie***
	5-7 Pairs of underwear/bra's **Underwire shall be removed from bra's*		***Snow Boots***
	1 pair of Athletic Shoes		***Jacket/Sweater/Hoodie/ etc….***
	1 pair of Flip Fops (Shower Shoes)		
	*****Residents are encouraged to bring a worn pair of shoes/boots to be used when therapy requires residents to be outdoors in wet or muddy conditions. i.e., fishing, cultural ceremonies. *****		

Personal Hygiene:

MUST BE ALCOHOL FREE, NEW, UNOPENED, and NON-AEROSOL.

Any products deemed unsafe, or without content information will be inventoried and stored in a secure room until discharge.

	Shampoo/Conditioner		***Q-Tips***
	Comb		***Face Wash/Mouth Wash (Non-Alcoholic)***
	Brush		***Shaving Cream/Gel***
	Hair ties		***Disposable razors***
	Lotion		***Deodorant***
	Toothpaste/Tooth brush (Needs cover)/Floss		***Chap Stick***
	Clippers (Fingernail/Toenail)		***Body Wash***
	Tweezers		***Foot Powder***
	Hair Gel/Mousse		***Feminine Hygiene products***

Prohibited Items:

The list below includes, but is not limited to all prohibited items. ***GPAYRTC Staff*** hold the sole responsibility to determine if an item(s) is ***Prohibited***.

Items that are deemed prohibited shall be confiscated, disposed, or inventoried and stored in a secure room until discharge

	String/Spaghetti strap tops		Jewelry/Watches (Earrings, Tongue rings. Etc.…)
	Cameras		Alcohol/Drugs of any kind
	Cell Phones/I-Pods/Mp3's/I-Pads/ etc.…		Over the counter medications
	Pillows/Blankets/Towels		Glass/Glass items
	Stuffed animals		Pens/Pencils/Tablets
	Aerosols/Hairsprays		Laptops/Mac's/Tablets
	Food/Gum/Soda/Seeds/ etc.…		Bluetooth Devices
	Tobacco products/ Drug paraphernalia		Make-up/Perfume/Cologne
	Lighters		Hats/Bandanas/Gang-Related clothing

The GPAYRTC will not be held financially responsible for prohibited items.