



13637 60<sup>th</sup> Street SW • Cokato, Minnesota 55321 • (320) 286-2922 • Fax (320) 286-2875

## **WELCOME TO VILLAGE RANCH!**

Thank you for choosing services provided by Village Ranch, Inc. These services may be in the form of individual therapy, family therapy, group therapy, and skills-based therapy (CTSS), and/or a combination of any of the available services through in-home, residential or foster care placement with Village Ranch or another organization.

### **HISTORY**

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The Village Ranch began in 1988 in Cokato, Minnesota offering adolescent males a place to live (group home) as well as outpatient therapeutic services. Since then, our original group home has grown to a Residential Group Home with a 34-bed capacity and onsite school. In 2009, we expanded to Anoka, Minnesota where outpatient individual, family, group therapy, and skills-based therapy is offered. In 2010, we opened our first “Independent Living Program” for adolescent males in Hutchinson, Minnesota with 12 beds and, most recently in April of 2015 we opened a similar 12-bed Independent Living Program for adolescent males in Rochester, Minnesota. All three of these residential locations offer a 24/7 staffed living environment, skills-based therapy services and outpatient therapeutic services.

Because we agree with you that consistency in therapy is important in addressing the challenges you and your family may be having, we try to schedule therapy sessions as convenient as possible; however, we understand emergencies happen and there will be times you will need to cancel appointments.

### **SERVICES AVAILABLE**

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Village Ranch, Inc. provides the following outpatient services: in-home individual and family skills-based therapy services, outpatient individual and family therapy, and diagnostic assessment services. We also offer residential group home and foster care placement which works in tandem with our outpatient therapeutic services. The children and families we support are in need of a rehabilitative mental health package and require varying therapeutic and skills-based therapy levels of intervention with the overarching design to enhance and support overall functioning.

The therapists you and your family will be working with are all master’s level and/or licensed professionals with many years of experience in the field and use a variety of therapeutic techniques. All mental health practitioners who provide skills-based services and training meet the state requirements for training and experience in providing skills-based services to your child/adolescent. Please note, skills-based therapy services are not available to those individuals over the age of 18.

Our philosophy is that every family system is unique, important, and has strengths. We believe that working as partners through relationships, support, and caring, families are



strengthened and experience greater success. The services provided, areas covered, and goals established are mutually agreed upon between client, family and provider.

**FINANCIAL RESPONSIBILITY (OUTPATIENT THERAPY SERVICES ONLY)**

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Copays, if applicable, are due at the time of your scheduled appointment and will be collected by your provider. The amount of your copay is listed on your insurance card.

**NO-SHOW POLICY (OUTPATIENT THERAPY SERVICES ONLY)**

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If you are unable to keep your scheduled appointments, please notify us at least 24 hours in advance so we can offer that time slot to someone on the waiting list. You may reschedule your appointment when you call us to cancel.

If there is a second no-show you will be required to meet with your therapist and, if applicable, your county worker and others involved with your treatment to discuss options about resolving the no-show issue and possibly transfer to another agency.

**LATE CANCEL POLICY**

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If you cancel your appointment with less than a 24-hour notice occasionally, we do understand. However, if a late cancel pattern develops, you will be required to meet with your therapist and, if applicable, your county worker and others involved with your treatment to discuss options about resolving the late cancel issue and possibly transfer to another agency.

**(OUTPATIENT THERAPY SERVICES ONLY - Not applicable to residential, group home, or foster care placements)**

After the first no-show appointment (without a phone call to cancel) you will receive a phone call to remind you of the missed appointment and to reschedule your appointment. You (not your insurance company) will be charged \$50 (using the credit card information that you provided to us during intake) for the time slot we were not able to fill when you were a no-show.

If there is a second no-show occurrence you will be required to meet with your therapist, county worker and others involved with your treatment to discuss options about resolving the no-show issue and possibly transfer to another agency.

We want to keep services available to you and your family. Please feel free to address issues with your therapist or skills worker so we can all work together to resolve issues.

**PARENTAL INVOLVEMENT**

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Through our experience, as well as available research, clients who do the best in treatment have involved families or support systems. Family involvement means actively supporting the therapeutic process which may include monthly family therapy sessions and general consistent contact with the client.

If the client is a child/adolescent involved with skills-based therapy services, please complete all the paperwork in a timely manner as we cannot hold the skills-based therapy spot longer than three (3) weeks due to our current waiting list for these services.



## VILLAGE RANCH INFORMED CONSENT/CLIENT RIGHTS & RESPONSIBILITIES

### CONFIDENTIALITY

The Minnesota Data Practices Act seeks to protect the privacy of the individuals when governmental agencies or private agencies under contract with public agencies collect data about them. The Minnesota Data Practices Act also helps people get information with this facility, whether the contact is in person, by mail, email, or by phone.

Every effort will be made to keep the information clients share with Village Ranch Inc. staff confidential. All client information is maintained as private and/or confidential, consistent with ethical guidelines of professional practice, and the statutes of the laws of the State of Minnesota. A written consent must be signed before outside persons or agencies can obtain information in records or from family workers.

The Clinical Supervisor supervises all casework and serves as a secondary source of support for families in crisis when practitioners and/or therapists are not available.

### CLIENT RECORDS

The client information we collect from you, or that you authorize us to collect from others, is used for the purposes listed below. Because this list of purposes covers a variety of services and programs, some of the purposes will not apply to your information.

- To determine your eligibility for services provided by this agency;
- To provide effective care and treatment of medical/social/psychological/educational needs;
- For other purposes specifically authorized by you;
- To make referrals to other agencies or professionals to provide additional services to you;
- To collect reimbursement from other agencies or individuals for services we give you;
- The legal or statute requirements, if any, of providing information;
- To evaluate and monitor our performance as an agency licensed by the State of Minnesota;
- To conduct evaluations and prepare statistical reports;
- We cannot guarantee confidentiality of data transmitted (i.e. video, voice, email, etc.)

### RELEASE OF CLIENT INFORMATION:

#### **Access by Client:**

As a client, you have access to all public and private records about yourself or your children. (See section on "Minors" for exceptions regarding children.) Upon request, you may review your records in the presence of one of our professional staff, and may request copies of records at your expense.

#### **Access by Others:**

The professional staff of Village Ranch Inc. will have access to information about you when their work requires it and for purposes of billing and collection of accounts in association with other professional consultation (e.g. accountant, attorney) if necessary. For training, supervision and/or consultation purposes, some clients may be asked to have their sessions observed and/or audio/video recorded. Such observations and/or recordings will only be conducted after the client has been fully informed of the specific uses of the observations/recordings and has consented to participate. All audio/video recordings will be destroyed following the training, supervision or consultation.

Individuals or entities outside of Village Ranch, Inc. who are authorized with a release signed by you (or guardian), may share information for purposes of consultation, evaluation, diagnosis, and program planning, when necessary to account for federal funds and program, when law enforcement personnel are investigating or prosecuting a criminal or civil proceeding, and with or without a release with appropriate personnel in an emergency.



**MINORS:** Under certain circumstances, minor clients have the legal right to request that client information be withheld from their parents. This request must be in writing, must explain the reasons for withholding the information, and what you expect the consequences could be if it is not withheld. Your therapist, in consultation with the professional staff will consider the request and a decision as to whether to withhold information will be made by Village Ranch, Inc. based on the best interests of the requesting minor.

In some cases, the law permits minors to consent to treatment and to withhold information from their parents with a formal request. This may be appropriate for a minor who is over the age of 16 and is financially independent and/or married, or when services relate to pregnancy, drug abuse or sexually transmitted disease. If you have any questions about this, ask the therapist who works with you.

**As a rule, we do not encourage the withholding of information from parents except when it is our clinical judgment that it would be clearly detrimental to the minor's welfare to disclose information.**

**MULTI-PARTY COUNSELING:** If you are involved in multi-party counseling such as couples or family therapy, our staff will treat all information acquired in that process in accordance with this confidentiality policy. In addition, Village Ranch, Inc. will stress the importance of maintaining confidentiality with all members of the family or couples therapy process, but we cannot be held responsible for breaches of confidentiality by other participants. Finally, records of such session belong to all participants and cannot be released without the consent of all participants.

In some circumstances individuals participating in couples or family counseling will also be involved in individual sessions with members of our professional staff. At times an individual may share information in individual sessions, which is of central importance to the couples or family therapy process. It is our belief that the family therapist should not place himself or herself in the position of holding secrets of families or couples. Thus, by signing this policy you give the therapist permission to disclose information when it is our clinical judgment that such disclosure is in the best interest of the couple or family.

## **LEGAL REQUIREMENTS**

In most cases, you are not legally required to provide the information requested. If there is such a legal requirement, you will be informed of the specific law that requires it. Generally, if you do not provide the information requested, the Court and/or your caseworker will be notified.

### **MANDATED REPORTING:**

Although each provider uses their own judgment regarding the safety of the client and family and decisions to report are made in consultation with the Clinical Supervisor, all employees of Village Ranch, Inc. are mandated reporters and are required by law to report any of the following situations:

- Instances of abuse or neglect of a minor or vulnerable adult
- Behavior that may be a threat to one's life or that of another person
- Receipt of a court order
- Report of sexual abuse by a health professional

### **OUR RESPONSIBILITIES:**

- To meet with you/your family in your home or our office weekly at a convenient time for you.
- To be prompt and accessible for scheduled meetings.
- To listen respectfully and be culturally sensitive.
- To provide you with appropriate support and information.
- To provide collaborating agencies or the court with reports regarding your progress.
- To provide crisis counseling during emergency situations.

### **YOUR RESPONSIBILITIES:**

- To commit to scheduled meetings.
- To communicate and cooperate with staff respectfully.
- To report changes in your condition or symptoms.
- To participate in the choice of goals and progress towards them.
- To notify your provider at least 24 hours in advance if you are unavailable for an appointment and need to reschedule.



**YOUR RIGHTS:**

- To be treated with respect, dignity, consideration and compassion
- Be informed of the qualifications of your practitioner and/or therapist (education, experience, professional counseling certifications, and license(s))
- Be informed of the limitations of the practitioner and / or therapist's practice to special areas of expertise (career development, ethnic groups, etc.) or age group (adolescents, older adults, etc.)
- Receive an explanation of services offered, your time commitments, fee scales, and billing policies prior to receipt of services.
- Confidential treatment of personal and medical records and the approval of refusal of their release to any individual outside of our agency.
- To see the contents of my file, the reasons for its retention, and any part of the file explained.
- To contest inaccuracies or incompleteness of the data maintained in the client record by submitting a written request to the author of said record. Village Ranch, Inc. replies to such requests within 30 days of receipt.
- Ask questions about the skills/therapy techniques and strategies and be informed of your progress.
- Participate in setting goals and evaluating progress toward meeting them.
- Be informed of how to contact the practitioner and/or therapist in an emergency situation.
- Request a referral for a second opinion at any time.
- Terminate the relationship at any time.
- Prompt and reasonable response to your questions and requests.
- Contact the appropriate professional organization with concerns or complaints relative to the professional's conduct.
- The right to initiate a complaint or grievance procedure and the appropriate means of requesting a hearing or review of the complaint. It is our hope that the client will approach our agency employee first to try resolving the issue directly. A complaint regarding the violation of client's rights may be filed by contacting Village Ranch, Inc. at 13637 60<sup>th</sup> St. SW, Cokato, MN 55321, or 320-286-2922 Ext. 202. You will receive a written response by our Director in 15 working days. If you are not satisfied with the actions taken, you may register a complaint with the Dept. of Human Rights, State Office Building, St. Paul, MN 55155, or 651-296-5663, or the Division of Licensing, Dept of Human Services Building, 444 Lafayette Road North, St. Paul, MN 55155 or 651-296-3971.
- You have the right to file a complaint with the appropriate state licensing Board.  
 Board of Psychology: (612) 617-2230                      Board of Social Work: (888) 234-1320  
 Board of Marriage & Family Therapy: (612) 617-2220    Board of Behavioral Health & Therapy: (612) 617-2178

**OUR RIGHTS:**

- Staff have a right to privacy.
- To be contacted by a client only to cancel or reschedule an appointment or in time of family crisis.
- Staff should have the right as for consultation on your case.
- Staff has the responsibility to report to authorities if the client has committed a crime or threatened to commit a crime while receiving services from Village Ranch, Inc.
- Staff have the right to not be harassed by the client, specifically sexual harassment. This includes suggestive sexual language, kissing, dating, sexual touching, sexual penetration, and/or any other type of sexual contact while they are providing treatment to you.

**CONSENT TO TREATMENT:** I affirm that prior to becoming a client of Village Ranch, Inc., I was given sufficient information to understand the nature of mental health services. I consent to participate in evaluation and treatment and I understand I may refuse services at any time. I am aware the service provider will participate in case consultation/ supervision, as required at the clinic. My signature below affirms my informed and voluntary consent to receive therapy/outpatient services.

	___/___/20__		___/___/20__
Client Signature	Date	Legal Guardian Signature	Date
	___/___/20__		___/___/20__
Therapist/Mental Health Practitioner	Date	Clinical Supervisor	Date



**VILLAGE RANCH APPLICATION FOR SERVICES**

Today's Date: \_\_\_/\_\_\_/\_\_\_\_

**A. CLIENT INFORMATION:**

\_\_\_\_\_ /\_\_\_/\_\_\_\_  
First Name MI Last Name Date of Birth

\_\_\_\_\_  
Street Address City State Zip Code County

(\_\_\_\_) \_\_\_\_ - \_\_\_\_ Living with: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_  
Phone First, Last Name (Parent, Foster Parent, etc.)

Office Location:  Cokato  Hutchinson  Rochester  Anoka

**SERVICES REQUESTED:**

- CTSS Services:     Individual Skills     Family Skills     Group Skills
- Individual Therapy     Family Therapy     Group Therapy     Family Focus
- Adolescent Sexual Health Curriculum     Sexuality-Specific Treatment     RISE     CLIMB

**1)** Are you currently receiving therapy or skills services?  YES  NO (If you answered YES, please provide the name and address of the agency providing the services)

\_\_\_\_\_  
Agency Street Address/City/State/Zip

**2)** Have you completed a past Diagnostic Assessment?  YES  NO (If you answered YES, please provide the name and address of the agency with the Diagnostic Assessment (DA) on file)

\_\_\_\_\_  
Agency Street Address/City/State/Zip

**B. REFERRAL REASON/GOALS:**

- Supportive Services     Psychoeducation     Prevent Placement     Reunification     Assessment Only

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

Estimated Length of Service(s): \_\_\_\_\_

**C. CLIENT AND CLIENT'S FAMILY (if applicable) STRENGTHS/ASSETS:**

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

*(Continued on next page)*



**D. REFERENT:**

Self  Therapist  Social Worker  Probation Officer  Foster Parent  Other: \_\_\_\_\_

\_\_\_\_\_  
First Name/Last Name Agency  
\_\_\_\_\_  
Street Address City State Zip Code (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Alternate Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Email Address

Specific needs/requirements of Village Ranch (reports, etc.): \_\_\_\_\_

**E. CUSTODIAL (LEGAL) GUARDIANSHIP:**

\_\_\_\_\_  
First Name/Last Name Relationship to Client (Parent, Foster Parent, etc.)  
\_\_\_\_\_  
Street Address City State Zip Code County  
Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Alternate Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Email Address

**F. FOR RESIDENTIAL AND GROUP HOME PLACEMENTS ONLY:**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Placing Worker Date of Placement Placement is:  Voluntary  Court Ordered

Is client: Adjudicated?  Yes  No Registered offender?  Yes  No  
Does client have community work service (CWS) hour or restitution obligations?  Yes  No  
If client has restitution, can their restitution be satisfied through CWS hours?  Yes  No  
Required hours/amount of restitution? \_\_\_\_\_

Comments on adjudication status and condition of placement: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Client's address prior to placement (if different from address in Section A: Client Information):  
\_\_\_\_\_  
Street Address City State Zip Code County



**VILLAGE RANCH FACE SHEET**

**I. CLIENT**

Client's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Race: \_\_\_\_\_ Sex:  M  F Ethnicity: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Place of Birth: \_\_\_\_\_

Social Security Number (optional): \_\_\_\_-\_\_\_\_-\_\_\_\_ Religion: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Special Medical Problems, Safety Concerns or Allergies: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  
Current Address: Street City State Zip Code Phone

Current Student:  Yes  No

Name of Last School Attended: \_\_\_\_\_

School Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Grade: \_\_\_\_\_ IEP:  Yes  No Currently Employed:  Yes  No

Employment Experience: \_\_\_\_\_

**IN CASE OF EMERGENCY, CALL:**

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**II. FAMILY (please complete if client is under 18 years of age)**

**PARENT/CAREGIVER DESCRIPTION OF THE PROBLEM (PLEASE INCLUDE FREQUENCY, INTENSITY, DURATION AND ONSET):**





PARENT/GUARDIAN NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_  
HOME PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_/\_\_/\_\_\_\_\_  
RACE: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_ RELIGION: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_  
CUSTODY RIGHTS: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

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PARENT/GUARDIAN NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_  
HOME PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_/\_\_/\_\_\_\_\_  
RACE: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_ RELIGION: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_  
CUSTODY RIGHTS: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

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PARENT/GUARDIAN NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_  
HOME PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_/\_\_/\_\_\_\_\_  
RACE: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_ RELIGION: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_  
CUSTODY RIGHTS: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

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PARENT/GUARDIAN NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_  
HOME PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_/\_\_/\_\_\_\_\_  
RACE: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_ RELIGION: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_  
CUSTODY RIGHTS: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

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SIBLING(S):	DATE OF BIRTH:	ADDRESS:
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____

Are there firearms in the home?  Yes  No

If yes, are they secure?  Yes  No

As Parent/Guardian it is my intention to be involved with:

Weekly Phone Calls and Visits     Staffings     Family Therapy     Off-Grounds Visits

Other (please explain): \_\_\_\_\_

**III. PAYMENT INFORMATION FOR CLIENT:** \_\_\_\_\_

**PARTY RESPONSIBLE FOR PAYMENT:**

- |  |  |
|--|--|
| <input type="checkbox"/> County of Residence                       | <input type="checkbox"/> Primary Insurance Company   |
| <input type="checkbox"/> County Different than County of Residence | <input type="checkbox"/> Secondary Insurance Company |
| <input type="checkbox"/> Self-Pay                                  |  |
| <input type="checkbox"/> Other: _____                              |  |

Responsible Party: \_\_\_\_\_ Relation: \_\_\_\_\_

Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy/Contract #: \_\_\_\_\_ ID #: \_\_\_\_\_

RXBIN#: \_\_\_\_\_ Phone: \_\_\_\_\_

Claims Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Insurance Coverage:  Dental Eye  Exams/Glasses  Prescriptions  Others \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy/Contract #: \_\_\_\_\_ ID #: \_\_\_\_\_

RXBIN#: \_\_\_\_\_ Phone: \_\_\_\_\_

Claims Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Insurance Coverage:  Dental Eye  Exams/Glasses  Prescriptions  Others \_\_\_\_\_

**FOR RESIDENTIAL AND GROUP HOME ONLY:**

Placement funded by:  DOC  DHS

Agency Responsible for Payment: \_\_\_\_\_



**BILLING AND PAYMENT POLICY**

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**INSURANCE BILLING**

Village Ranch, Inc. requires all insurance information be provided before services begin. This means any, and all, primary and secondary insurance policies on which the client is listed, i.e. mother, father, step-parents, etc., as well as medical assistance, so that claims can be properly submitted and processed.

**CO-PAYS, CO-INSURANCE, AND DEDUCTIBLES**

Co-Pays, if applicable, are due at the time of your scheduled appointment and will be collected by your provider. The amount of your co-pay is listed on your insurance card. If your policy is subject to a deductible, you will receive a bill from Village Ranch if you have not yet met any deductibles for your policy/policies. Any co-insurance due after claims are processed will be billed to the client as well. It is highly recommended that you apply for medical assistance, so that, if you qualify, your financial responsibility can be reduced or perhaps eliminated.

**COVERAGE LAPSES**

If, at any time and for any reason, your policy is terminated, it is your responsibility to inform Village Ranch immediately so steps can be taken to ensure services are not interrupted. This applies to commercial policies (ones for which a monthly premium is paid) **AND** medical assistance. If coverage is not reinstated, you will be responsible for any, and all, fees for services. Talk to your social worker or county contact for information regarding medical assistance lapses. If you are unable to meet these requirements, services may be suspended.

**SLIDING FEES**

If you do not have insurance or medical assistance of any kind, a sliding fee schedule is available for those who qualify. Please speak to your provider for assistance.

**By signing below, I understand this Billing & Payment Policy:**

\_\_\_\_/\_\_\_\_/\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
Date                                      Signature of Client or Authorized Person      Authorized Person's Authority to Sign (proof required)

Reason client is unable to sign:  Minor     Deceased     Other: \_\_\_\_\_



**IV. CLIENT'S COUNTY/STATE CARE TEAM**

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**SOCIAL WORKER:** \_\_\_\_\_ COUNTY: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_  
PHONE: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ CELL: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
FAX NUMBER: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_  
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**CHILD PROTECTION WORKER:** \_\_\_\_\_ COUNTY: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_  
PHONE: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ CELL: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
FAX NUMBER: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_  
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**MENTAL HEALTH CASE WORKER:** \_\_\_\_\_ COUNTY: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_  
PHONE: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ CELL: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
FAX NUMBER: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_  
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**PROBATION OFFICER:** \_\_\_\_\_ COUNTY: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_  
PHONE: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ CELL: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
FAX NUMBER: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_  
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**GUARDIAN AD LITEM:** \_\_\_\_\_ COUNTY: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_  
PHONE: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ CELL: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
FAX NUMBER: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_  
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\_\_\_\_\_: \_\_\_\_\_ COUNTY: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_  
PHONE: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ CELL: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
FAX NUMBER: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_  
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**VILLAGE RANCH, INC. RELEASE OF INFORMATION**

**Village Ranch Residential**  
13637 60<sup>th</sup> St. SW  
Cokato, MN 55321  
Phone: (320) 286-2922 Fax: (320) 286-2875

**Village Ranch Cokato Outpatient**  
13637 60<sup>th</sup> St. SW  
Cokato, MN 55321  
Phone: (320) 286-2922 Fax: (320) 286-5140

**Village Ranch Foster Care**  
13637 60<sup>th</sup> St. SW  
Cokato, MN 55321  
Phone: (320) 286-2922 Fax: (320) 286-5140

**Village Ranch Hutchinson Group Home**  
851 Dale Street SW, PO Box 305  
Hutchinson, MN 55350  
Phone: (320) 587-3447 Fax: (320) 286-2875

**Village Ranch Rochester Group Home**  
1117 1st Ave NE  
Rochester, MN 55906  
Phone and Fax: (507) 258-3447

**Village Ranch Anoka Outpatient**  
12 Bridge Square, Suite 207  
Anoka, MN 55303  
Phone: (763) 712-9209 Fax: (763) 712-9200

Client's Legal Name: (please print) \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Previous Names: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone (home/main): (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Other: (\_\_\_\_) \_\_\_\_-\_\_\_\_

1. **I would like Village Ranch, Inc. to:**
- Exchange information with
  - Release my records to
  - Obtain my records from

Person, Clinic, Organization Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_-\_\_\_\_

2. **I would like the following records released:** All pertinent records, or check all that apply below:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Discharge Summary       | <input type="checkbox"/> School Reports | <input type="checkbox"/> Medical Reports |
| <input type="checkbox"/> Mental Health Records   | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Evaluations/Assessments | <input type="checkbox"/> Legal Records  | <input type="checkbox"/> Social History  |
| <input type="checkbox"/> Social Service Records  | <input type="checkbox"/> Other: _____   |  |

3. **Purpose:**
- Care Coordination
  - Treatment Planning
  - Evaluation/Assessment
  - Personal Use (*mark personal and confidential*)
  - Other: \_\_\_\_\_

4. **Staff member requesting information:** \_\_\_\_\_ (\_\_\_\_) \_\_\_\_-\_\_\_\_  
Name Phone

5. **I understand the following:**
- Except for psychotherapy notes (which are not included in my medical record), all records will be released to the hospital, clinic or person named above. This includes details about treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions, and AIDS/HIV.
  - If I do not want these to be released, I will place a check mark here:  I do not want the following records released: \_\_\_\_\_
  - If I change my mind, I may write to the address in Section 1 to stop the release of my records. This will not apply to records that have already been released.
  - This form expires one year after I sign it, or on (expiration date): \_\_\_/\_\_\_/\_\_\_
  - There may be a fee for releasing these records.
  - Once the records are released to the hospital, clinic or person named above, the clinic or hospital releasing my records cannot prevent them from being shared by a third party. At that point, the records may no longer be protected by state or federal privacy laws.
  - To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.
  - If I do not sign this form, I will still be treated, unless treatment is part of a research project.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signature of Client or Authorized Person Authorized Person's Authority to Sign (proof required)

Reason client is unable to sign:  Minor  Deceased  Other: \_\_\_\_\_





**Consent for Participation in the  
MCCCA Student Data Reporting System**

Village Ranch, Inc. is engaged in ongoing data collection and evaluation of its services through the Minnesota Council of Child Caring Agencies (MCCCA). In cooperation with youth-serving agencies throughout the state, MCCCA collects information provided by member agencies on youth at intake, discharge and six (6) months after discharge. A confidential satisfaction survey will also be sent or given to you at discharge.

**This information does not identify individual children or families by name.**

You and your child are invited to participate in this evaluation process so that we may better serve all children and families. The information collected will be used in summary form to improve outcomes, complete funding report requirements, and advocate for services for children and families.

If you agree to participate, Village Ranch, Inc. agrees that:

1. All information collected will be treated as private. This will be ensured through the use of identification numbers and publication of summary results.
2. The names of children/youth/parents will not appear on any data collection instrument, and will be unknown to anyone receiving the data or in any document describing the results.
3. Participation is completely voluntary. Your decision about participation will not affect your relationship with Village Ranch, Inc. If you decide to participate you may withdraw this permission at any time.

If you agree to participate, you authorize Village Ranch, Inc. to:

Include information on your child/family in this data collection, evaluation and follow-up program. **This information will not identify your child or family by name.**

Contact you and/or the County worker six (6) months after discharge for follow-up information.

**NAME OF CHILD:** \_\_\_\_\_

**X**  
\_\_\_\_\_  
Client/ Legal Guardian Signature Date

**X**  
\_\_\_\_\_  
Client/ Legal Guardian Signature Date



**CONSENT FOR MEDICAL TREATMENT**

I hereby authorize the Village Ranch, Inc. Staff to consent to any routine and emergency medical care (including surgery, anesthesia, tests, etc.) to for medical, dental, and eye exams or treatment, under general or special supervision, and on the advice of a physician, nurse, dentist, or surgeon duly licensed by the State of Minnesota.

I also authorize the Village Ranch, Inc. to administer medication to the below-named minor as directed and as prescribed by a duly licensed physician or surgeon.

This authorization shall remain in effect so long as the named minor below is in the care and control of Village Ranch, Inc.

Foster care and residential/group home placement please answer the next two questions:

**I AUTHORIZE QUALIFIED MEDICAL PERSONNEL TO:**

**ADMINISTER REQUIRED IMMUNIZATIONS:**  YES  NO

**ADMINISTER RECOMMENDED SEASONAL VACCINATION:**  YES  NO

.....

**ILLNESS/ALLERGY DISCLOSURE**

Please indicate when and what illnesses or allergies your child has experienced and the action that was taken. Please use a separate piece of paper if more space is needed.

<b>DATE:</b>	<b>ILLNESS/ALLERGIES:</b>	<b>ACTION TAKEN:</b>
<i>Example: 9/25/98</i>	<i>Strep throat, chicken pox, etc.</i>	<i>Doctor, Antibiotics, Rest</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

By signing this document, I acknowledge I have authority to consent to medical treatment for:

\_\_\_\_\_ (Child's name)

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Client/Legal Guardian Signature Date





**TEXT AND EMAIL NOTIFICATIONS FROM PROCENTIVE SOFTWARE**

Client's Name: \_\_\_\_\_

**OVERVIEW**

Procentive is the trusted electronic health records system (EHR) for behavioral health. This system allows us to communicate with parents through text and email. With the input of your text number and/or email address our system allows us to set up notifications that will be directly sent to your phone and/or email address to remind you of an upcoming appointment or to review a document that requires a signature.

**HOW IT WORKS**

- Text/Email Notifications: Our system will automatically send you a text and/or email reminder two (2) days before and the day of your scheduled appointment, reminding you of your upcoming appointment.
- Email Notifications: Using the kiosk feature we are also able to send documents that require a signature electronically through email. The provider will send an email with the subject line "Village Ranch Paperwork". There will be a link directing you to the document.  
\*(Note this document can only be opened once). Once opened you can review the document and sign it in the designated signature box using your mouse.

With your permission, we ask that you provide us with your text number and email address:

Text Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_@\_\_\_\_\_.\_\_\_\_\_

How would you prefer to be notified for an upcoming appointment?  Text  Email

\_\_\_\_\_  
Client/Legal Guardian Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Client/Legal Guardian Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date



# RESIDENTIAL ONLY FORMS





be held. All verbal communication must be confirmed in writing by the Agency within five (5) working days.

5. Village Ranch shall provide Social Service Progress Reports to the Agency each quarter after the staffing. Written progress reports will be supplied upon request.
6. Village Ranch agrees to provide the Agency and the child's family with information relative to the procedures at the Residential Facility.
7. The Agency must provide Village Ranch with the following information in writing prior to placement:
  - a) Social history on child and family;
  - b) Results of recent psychological and/or physical consultations;
  - c) Results of physical examination which has been given within the last year as well as history of health problems and immunization records;
  - d) Educational data which would include achievement scores;
  - e) The Agency case record number and when available, the Medical Assistance number or statement of financial responsibility for medical services.
8. The Agency's participation is required at the time of placement, the Intake Staffing and Reviews. The Agency is responsible for implementing and carrying forth work with the family and to provide reports indicating the goals and objectives of family treatment and the time limits in which they will try to reach them.

At the time of placement, the Agency will have completed a Face Sheet provided by Village Ranch. He/she would also have the consent forms relative to placement signed by the parents or guardian.

\_\_\_\_\_  
**Agency Worker Signature**

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

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

\_\_\_\_\_  
**Village Ranch, Inc. Signature**

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

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



**VILLAGE RANCH BANKING CONTRACT**

As a resident of Village Ranch (Hutchinson or Rochester), you are expected to attain a job as quickly as you can, when staff feel you are ready. Part of this employment experience is learning to balance your spending money and, at the same time, saving money for your future. It is our desire to help you with this so the following is an agreement we are asking you to sign to allow us to assist you in this.

- You may keep 20% of your paycheck for personal spending either in cash or a debit card.
- A spending register may be required of you if staff feel you need to keep better track of how much you spend.
- You will put 80% of your paycheck into a general savings account that the House maintains. A record of your deposits will be kept.
- When you are discharged from the Village Ranch, you will be given any savings you have accrued during your time with us.

\_\_\_\_\_  
**Client/Legal Guardian Signature**

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

\_\_\_\_\_  
**Client/Legal Guardian Signature**

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



## VILLAGE RANCH CELL PHONE CONTRACT

During your stay with us at Village Ranch (Hutchinson or Rochester), you may earn the privilege to purchase and keep a cell phone, once certain requirements and levels are met. This privilege comes with responsibilities and accountability. This contract is to ensure you understand and agree to the expectations of your responsibilities and accountability so we may assist you in keeping and learning the privilege of a cell phone.

Below is what is expected of you.

- The privilege of having a cell phone may be earned once you have attained Level 2 of our program.
- You must purchase the cell phone with your own money or you may keep one you have previously purchased.
- If your cell service is on your parent’s plan you will be expected to send them money each month to assist with paying your bill. The amount depends on your plan and service.
- You may also be expected to pay Village Ranch an additional \$5-\$10 each month for the accountability/monitoring service we use. Our monitoring service allows us to view your text messages, emails, messages, phone calls, web activity, photos, videos, social networking activity, and track whereabouts, etc.
- If you do not already have a cell phone, staff will assist you with purchasing one as well as setting up the account with the provider of your choice.
- Cell phones are to be turned off and placed on a charger by the fireplace each night at bedtime (9:30 p.m.).
- Cell phones are not to be brought to school. You may not use your cell phone until after school.
- You will lose your cell phone, for a time determined by staff, if you misuse it by:
  - Accessing inappropriate websites
  - Using your cell phone to harass another person
  - Use your cell phone to contact anyone you are prohibited to contact

By signing below, you are agreeing to the terms states above for having and maintaining the privilege of a cell phone and cell phone service.

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

\_\_\_/\_\_\_/\_\_\_  
Date

\_\_\_\_\_  
Legal Guardian (if applicable) Signature

\_\_\_/\_\_\_/\_\_\_  
Date

\_\_\_\_\_  
Village Ranch Staff Signature

\_\_\_/\_\_\_/\_\_\_  
Date

**VILLAGE RANCH INTERNET/SOCIAL MEDIA INFORMATION**

<b>EMAIL</b>	Login	Password

<b>FACEBOOK</b>	Login	Password

<b>TWITTER</b>	Login	Password

<b>INSTAGRAM</b>	Login	Password

<b>OTHER</b>	Login	Password



**VILLAGE RANCH DISCLAIMER OF RESPONSIBILITY**

I, \_\_\_\_\_, do hereby release Village Ranch, Inc. and its employees from responsibility (either monetary or replacement) for personal items that I insist upon keeping rather than returning to home. If any personal item is broken or stolen, I will bear sole responsibility for its loss and/or replacement.

If I acquire additional items during my stay at Village Ranch, which includes any clothing or personal items, I am fully responsible for informing staff and documenting the changes on my inventory sheet immediately.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Client/Legal Guardian Signature Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Client/Legal Guardian Signature Date

**MEDICATION MANAGEMENT**

Resident's Name \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

TYPE OF MEDICATION	DOSAGE	QUANTITY UPON ADMISSION
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

- Has parental/guardian verbal/written consent been given?  YES  NO
- Has Village Ranch nursing staff been notified?  YES  NO
- Has the medication been verified by prescribing pharmacy?  YES  NO

Please advise how the medication was verified and give documentation of parental/guardian consent:

\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Village Ranch Staff Signature Print Name Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Parent/Guardian Written Consent Date





**Village Ranch Drug Use Policy**

The Village Ranch prohibits any use of illegal or non-prescribed drugs or medications of any type or sort.

If a client is found to be using, distributing, or in possession of illegal drugs, while a resident of the Rochester House, he will lose privileges and receive consequences determined by staff.

The guidelines of said loss of privileges and consequences will be as follows. However, these are not conclusive and may be altered at the discretion of staff.

The House staff will take into consideration a client’s amenability to treatment and timeframe between infractions of this expectation when determining consequences for offences.

**Use of illegal drugs or non-prescribed medications – 1<sup>st</sup> offense:**

- Loss of all privileges in the House
- Table time – determined by staff
- Reduced to Level 1
- Loss of any extracurricular school activity or events
- Loss of any House off campus non-supervised activity

**Use of illegal drugs or non-prescribed medications – 2<sup>nd</sup> offense:** *(In addition to consequences above)*

- Loss of job
- Rochester “House Arrest”
- An emergency staffing will be arranged to discuss the potential options for the Client.

**Use of illegal drugs or non-prescribed medications – 3<sup>rd</sup> offense:**

- Unsuccessful discharge from Rochester House

Possession of or bringing illegal drugs or non-prescribed medications onto Hutchinson House property:

- Unsuccessful discharge from Rochester House

Distribution (give, sale or trade) of illegal drugs or non-prescribed medications:

- Unsuccessful discharge from Rochester House

The Village Ranch Rochester House reserves the right to discharge a client unsuccessfully at any time for any reasons of non-cooperation with our program.

Client Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Worker Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_





**VILLAGE RANCH GRIEVANCE POLICY & PROCEDURES**

**A. INTERNAL PROCEDURE:**

1. Residential Home Staff will provide a Resident who wishes to report a grievance with a copy of the Grievance Form.
2. Resident Grievance Forms completed will be delivered by the staff without reading, altering, interference, or delay to the Chief Executive Officer.
3. Upon receipt of the Resident’s Grievance, the Chief Executive Officer will conduct an investigation (*if the grievance is not frivolous*) into the Resident’s complaint. The Chief Executive Officer will submit a written report of findings and recommendations, if any, to the Grievance Committee within three (3) working days from the time the grievance was received.
4. When a grievance is of an emergency matter, the Chief Executive Officer will conduct an investigation into the Resident’s complaint and complete a written report and the action taken, if any, within 24 hours from the time the grievance was received.
5. The Chief Executive Officer will provide the Resident reporting the grievance with a copy of his findings and recommendations.
6. The Grievance Committee will consist of a member of the Village Ranch Board, a probation/law enforcement officer and the Residential Home Chaplain.
7. The Grievance Committee will:
  - a. Review the Chief Executive Officer’s investigation and findings.
  - b. Hear any added information or rebuttal from the Resident reporting the grievance.
  - c. Discuss possible corrective plans of action with the Chief Executive Officer and complaining resident.
  - d. Decide on the Chief Executive Officer and Residential Home staff to take steps necessary to implement the corrective plan of action and report back to the Committee on the results of said plan within 30 days.

**B. EXTERNAL PROCEDURES**

1. Residential Home staff will provide a Resident who wishes to report a grievance with a copy of the Grievance Form.
2. Resident Grievance Forms, if not submitted to the Chief Executive Officer will be mailed to the Residential Home Board according to procedures applying to regular correspondence/private mail.
3. The Residential Care Staff will provide postage to Residents who wish to mail grievances to the Chief Executive Officer or Village Ranch Board.
4. The Residential Care Staff will cooperate with the Grievance Committee in order to resolve the grievance issues.

\_\_\_\_\_  
Client/Legal Guardian Signature

\_\_\_/\_\_\_/\_\_\_  
Date