Admissions Packet

PARENT CHECKLIST

A. Forms signed & returned before placement or transportation occurs.
B. Immunization records must be included in admissions paperwork.
C. Copy of birth certificate must be included in admissions paperwork.
D. Current physician's orders or a copy of the current prescription with the physician's signature is required at the time of placement. No medication may be administered without this information. This information may be faxed by the physician's office to (435) 638-7582 or e-mailed to nursing@sorensonsranch.com
E. Interstate compact agreement filled out, signed, & forwarded to home state.
F. Copy of insurance cards, front & back must be included in admissions paperwork
G. Pre-approval by insurance, if residential treatment benefits apply. Include all information obtained from insurance; i.e., name of case manager, phone number of case manager, and case number. (Check your benefits to see if you indeed do have coverage specifically for Residential Treatment Centers.)

FORMS

Parent Checklist
Application for Admission
Albertson's Prescription Form
Intake & Assessment Forms
Power of Attorney
Medical Records Release
Signature Page
School Records Release
Confidential Release Forms
Insurance Release
Credit Card Charge Authorization
Interstate Compact Information
Individual Treatment Plan Input
Insurance Info for Residential Treatment Coverage
Progress Report Listing
Telephone & Mail Contact Listing

SORENSON'S RANCH SCHOOL
P. O. BOX 440219
KOOSHAREM, UT 84744
(435) 638-7318 FAX (435) 638-7582
email: admissions@sorensonsranch.com

Application For Admission
Insurance – Billing Information
Transportation Authorization

STUDENT#
ADMISSION DATE

THIS FORM MUST BE FILLED IN COMPLETELY! PLEASE MARK THROUGH WHAT DOES NOT APPLY.

Prior to the admission of student, this paperwork must be completed and returned. Student may be rejected by testing/intake committee up to 30 days after arrival at campus. A representative of SRS will contact the parent/s or caseworker within two weeks of admission to explain specifics of the program. Refund of all tuition not used will be made if student is rejected in testing.

STUDENT

APPLICANT/STUDENT'S NAME	LAST	FIRST	MIDDLE
ADDRESS OF APPLICANT/STUDENT	CITY	STATE	ZIP CODE

SOCIAL SECURTIY #	AGE	BIRTHDATE	PLACE OF BIRTH	SEX ☐ M ☐ F	HAIR COLOR	EYE COLOR	HEIGHT	WEIGHT

WAS APPLICANT ADOPTED? _____ NO _____YES IF YES, AT WHAT AGE	RACE	RELIGION	GRADE LEVEL ENTERING

FATHER

FATHER'S FULL NAME	ADDRESS		
PHONE _____HOME ____CELL	BIRTHDATE	SOCIAL SECURITY #	EMAIL ADDRESS
EMPLOYER ☐ FULL TIME ☐ PART TIME	ADDRESS OF EMPLOYER	TELEPHONE # OF EMPLOYER	

MOTHER

MOTHER'S FULL NAME	ADDRESS		
PHONE ____HOME ____CELL	BIRTHDATE	SOCIAL SECURITY #	EMAIL ADDRESS
EMPLOYER ___ FULL TIME ___ PART TIME	ADDRESS OF EMPLOYER	TELEPHONE # OF EMPLOYER	

ARE PARENTS MARRIED ☐ NO & LIVING TOGETHER ☐ YES	IF NO, WHO HAS CUSTODY:	WHO IS STUDENT LIVING WITH CURRENTLY:	HOW DID YOU HEAR ABOUT US?

PAYMENT INFO

PLEASE PROVIDE NAME, ADDRESS & PHONE OF PERSON OR AGENCY RESPONSIBLE FOR PAYING MONTHLY TUITION

NAME OF PERSON BILLS ARE TO BE SENT TO:	RELATIONSHIP OR AGENCY	TELEPHONE	
ADDRESS	CITY	STATE	ZIP

ALLERGIES:

CURRENT MEDICATIONS:

MEDICAL BILLING

*** ATTENTION MEDICAL PROVIDERS: PLEASE USE THIS ADDRESS TO SEND ALL MEDICAL BILLS TO AFTER BILLING**

NAME OF PERSON BILLS ARE TO BE SENT TO	RELATIONSHIP	TELEPHONE	
ADDRESS OF PERSON BILLS ARE TO BE SENT TO	CITY	STATE	ZIP

*Please provide insurance information in the boxes below. This information will be provided to all medical facilities that treat your child, in order for your insurance billings to be correct the information below must be complete. Copies of the front and back of your insurance card are also required to accompany this form. Sorenson's Ranch School will not be responsible for any billing incurred due to missing or incorrect information.

MEDICAL INSURANCE

INSURANCE COMPANY	INSURANCE TELEPHONE		
CLAIMS ADDRESS			
POLICY HOLDER'S NAME	POLICY HOLDER'S SS#	POLICY HOLDER'S BIRTHDATE	
GROUP #	POLICY# CONTRACT# ID#	EMPLOYER NAME	EMPLOYER PHONE

I/We, the undersigned, hereby certify that I/we have custody of applicant/student and that I/we take financial responsibility for all costs incurred during treatment. I/We further authorize any staff member of Sorenson's Ranch School to provide transportation or authorization/confirmation for emergency and/or medical treatment for my/our child listed above at any medical facility should it be deemed necessary. I/We understand this will be done on my/our behalf should I/we be unable to be contacted by Sorenson's Ranch School at time of said emergency.

_______________________________ Father or Guardian's Printed Name

_______________________________ Father or Guardian's Signature

_______________________________ Mother or Guardian's Printed Name

_______________________________ Mother or Guardian's Signature

Date Signing_______________________ 20_____ Hour_______

Date Signing______________________ 20_____ Hour ______

Sorenson's Ranch School

Pharmacy
Insurance Form
360 South Main Street
Richfield, Utah 84701
(435) 896-5759

Please provide <u>all</u> of the following information to help the pharmacy staff process your prescriptions under your insurance.

Name of the student:____

Date of birth of the student: __________________________/____________ Gender: _______________________

Allergies to any medications, prescription or over-the-counter: ____

Please list all current medications that the student is taking: ____

Does the student's current medical insurance have prescription coverage?________________________________

Name of the insurance carrier:____

Name of the card holder on the insurance:____

Cardholder identification number/Medicaid number:____

Group number: ____

Person Code of the student (i.e. Cardholder is 01, spouse 02, 1st child 03, 2nd child 04, etc.):___________________

The name of the parent(s) or guardian(s) to contact concerning prescription/insurance issues:_________________

Telephone number for contact person:

Home: ___________________________ Work: ______________________________

We will do our best to process the prescriptions under your insurance; but please understand that some insurance companies do not contract with pharmacies in Utah. Please include a legible copy of the front and back of the current prescription card(s) to help us serve you better. If you have any questions, feel free to call at (435) 896-5759.

ORDERS FOR CURRENT MEDICATION

A current medication list and signature of prescribing physician must be sent prior to or with student when admitted to SRS. Medications will not be administered without this sheet. This includes any herbal or over the counter medication the student takes on a regular basis.

Student Name: ____

Is the student taking any over the counter or herbal medication regularly? YES NO
(If yes, please list below)

Current Medication	Dose	Schedule	Route
________________	______________	_______________	_____________
________________	______________	_______________	_____________
________________	______________	_______________	_____________
________________	______________	_______________	_____________
________________	______________	_______________	_____________
________________	______________	_______________	_____________
________________	______________	_______________	_____________

Physician Comments: ____

____

Print Physician's Name: ____

Physician's Signature: _________________________________ Date: _____________________________

MEDICATION HISTORY:
Please list any prior medications and the reason for discontinuing.

____

____

____

____

____

____

____

____

SORENSON'S RANCH SCHOOL
PARENT INITIAL INFORMATION FORM

Dear Parent/Guardian we ask that you please fill out the following information as completely, specifically, and timely as possible. This information will help us better understand your child's current situation so we can more fully address these presenting issues in a like manner.

Child's name:____________________________ DOB:_________/_________ Age:_________

PRIMARY PROBLEM

What is the primary reason for sending your child to Sorenson's:

What are the secondary reasons?

How long have the above listed been a problem? Do you see any underlying cause to these problems?

DEVELOPMENTAL HISTORY

PRENATAL/BIRTH HISTORY

Health of Mother: ☐ Good ☐ Fair ☐ Poor ☐ Do not know

Did the mother use any of the following during pregnancy?
☐ Alcohol ☐ Marijuana/Cocaine/Crack
☐ Cigarettes ☐ Coffee/Caffeine Drinks
☐ Prescription drugs (list):___________________ ___________________
___________________ ___________________
___________________ ___________________
☐ None of the above

Any medical complications during pregnancy? ☐ Yes ☐ No

Comment:____

Length of Pregnancy in months or weeks if known:___________________

Birth Weight:___________________

Were there any complications during or following birth(check all that apply)?

☐ Baby given oxygen	☐ Problems breathing
☐ Baby on heart monitor	☐ Problems eating/digesting
☐ Blood transfusions (baby)	☐ Problems sucking
☐ Birth defects	☐ Rashes
☐ Delivery by cesarean section	☐ Very active
☐ Delivery aided by instrument	☐ Very quiet
☐ Incubator	☐ Jaundice
☐ Other____________________	
☐ None of the above	

EARLY DEVELOPMENT

Behavior	Age	Comments
Walking	_________	____
Talking	_________	____
Toilet Trained	_________	____

Overall, you feel your child developed at the following rate: ☐ Slow ☐ Normal ☐ Rapid

Comments:____

During the first three years of life, your child frequently exhibited (Check all that apply):

☐ Accident prone behavior	☐ Lack of coordination	☐ Avoidance of cuddling
☐ Over-active behavior	☐ Colic	☐ Destructive behavior
☐ Restless behavior	☐ Withdrawn behavior	☐ Unresponsive to discipline
☐ Distractibility	☐ Self-hurting behavior	☐ Extreme mood changes
☐ Temper tantrums	☐ Feeding Problems	☐ Head banging
☐ Problems with sleeping/walking patterns		
☐ None of the above		

Comments:____

SEXUAL HISTORY

Is your child: ☐ Prepubescent ☐ Pubescent

(For Female Student):

Menses onset:__________ Menstrual history normal: ☐ Yes ☐ No

Frequency of Menstrual cycle:____

Special Considerations:____

I give approval for my daughter to be given birth control____ Disapproval____.

I would like to discuss the issue of birth control further with SRS Personnel____.

_________________________________ __________________

Parent/Guardian signature Date

To the best of your knowledge your child is:

sexually active:
uses contraceptives: ☐ Yes ☐ No ☐ Unknown
history of pregnancy: ☐ Yes ☐ No ☐ Unknown
history of abortion: ☐ Yes ☐ No ☐ Unknown
fathered a child: ☐ Yes ☐ No ☐ Unknown
Comments:______________________________

contracted a venereal disease: ☐ Yes ☐ No ☐ Unknown
If yes, please list type, medications, and date of last treatment:______________________________

Do you have any concerns regarding your child's sexual development or sexual orientation?
☐ Yes ☐ No
Comments:______________________________

HEALTH/MEDICAL HISTORY
Sex:__________ Age:__________Height:__________Weight:__________
Primary Care Physician/Pediatrician(include address and telephone):______________________________

Does your child have any allergies? ☐ Yes ☐ No If yes, please specify:
____

Are childhood immunizations up to date? ☐ Yes ☐ No ☐ Unknown

Date of last Tetanus shot:__________

I give permission for my child to have an annual flu immunization at an additional cost.

______________________ ______________
Parent/Guardian signature Date completed

Date of last complete Physical:__________ Date of last Dental Check up:__________

Has your child been diagnosed and/or currently being treated for any of the following?

☐ ADHD	☐ heart problems	☐ anemia	☐ HIV/AIDS
☐ asthma	☐ cancer/Leukemia	☐ cerebral Palsy	☐ diabetes
☐ ear Infections	☐ encephalitis	☐ epilepsy	☐ fever above 105 degrees
☐ hearing problems	☐ hydrocephalus	☐ lead poisoning	☐ loss of consciousness
☐ meningitis	☐ mental Retardation	☐ seizures	☐ vision problems
☐ anorexia	☐ appendicitis attack	☐ arthritis	☐ musculoskeletal condition
☐ bladder infection	☐ bleeding/clotting	☐ bronchitis	☐ bulimia
☐ chicken pox	☐ colitis	☐ concussion	☐ constipation
☐ convulsions	☐ diarrhea	☐ dislocations	☐ Eczema
☐ fainting	☐ fracture	☐ German measles	☐ hay fever
☐ hepatitis/jaundice	☐ hernia	☐ hives	☐ kidney disease
☐ measles	☐ migraine	☐ mononucleosis	☐ mumps
☐ pneumonia	☐ polio	☐ rheumatic fever	☐ scarlet fever
☐ sinusitis	☐ tonsillitis	☐ tuberculosis	☐ typhoid fever
☐ ulcer, stomach	☐ whooping cough	☐ Other__________	
☐ None of the above			

Comments (list year of occurrence for any checked):______________________________

List any family diseases and give a brief history:____

How would you describe the nutritional value and balance of your child's diet:

☐ Good ☐ Fair ☐ Poor

Any diet restrictions:____

Does your child have an eating or sleeping problem? (Check all that apply)

☐ Dieting
☐ Overeats
☐ Picky eater
☐ Recent weight gain
☐ Recent weight loss
☐ Refuses to eat
☐ Vomiting
☐ Other_________________
☐ Other______________
☐ Does not want to sleep alone
☐ Bed-wetting
☐ Difficulty falling asleep
☐ Nightmares
☐ Sleeps too much
☐ Soiling
☐ Trouble staying asleep
☐ Very restless while sleeping
☐ None of the above

Has your child had any surgeries/accidents/conditions requiring hospitalization or same day surgery? ☐ Yes ☐ No

Date:______________ Conditions:____

Is your child taking any medication (prescription, over-the-counter, or herbal)? ☐ Yes ☐ No

List medication/dosage/time and purpose:

1)____

2)____

3)____

4)____

5)____

Are there any other medical conditions that would limit your child's participation in our program? ☐ Yes ☐ No

Comments:____

SIGNIFICANT EVENTS

☐ Change of School ☐ Death in family ☐ Divorce or separation
☐ Move to a new place ☐ Serious illness or injury to family member/friend
☐ Frightening experience for child/adolescent
☐ Loss of someone close to child/adolescent
☐ None of the above

Comments:____

BEHAVIORAL/HEALTH HISTORY

Has your child had prior mental health services, counseling, and/or drug/alcohol treatment? ☐ Yes ☐ No

Outpatient

Therapist/Program	Date	Effectiveness
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

Hospital	Date	Effectiveness

Has your child (check all that apply):

- ☐ Physically harmed another individual, pet, or small animal?
- ☐ Received medication in the past for emotional, learning or behavioral problems?
- ☐ Run away from home?
- ☐ Started a fire?
- ☐ Talked about or attempted suicide?
- ☐ Threatened to physically harm anyone?
- ☐ None of the above

Comments:____

Has your child ever experienced or witnessed:

☐ Domestic violence ☐ Rape Sexual Assault ☐ Emotional Abuse
☐ Sexual Abuse ☐ Physical Abuse ☐ Other significant trauma
☐ None of the above

Comments:____

Has your child been previously diagnosed (by whom?):_______________________________

PSYCHOLOGICAL TESTING

Has your child had previous psychological testing or evaluation? ☐ Yes ☐ No

If yes, then please send with Admissions Packet.

ACTIVITIES OF DAILY LIVING

Check areas of difficulty your child displays when performing daily activities:

☐ Adapting to changes ☐ Attending to tasks ☐ Decision making
☐ Following a routine ☐ Goal setting ☐ Learning
☐ Problem solving ☐ Performing Self Care (hygiene, grooming, bathing, etc.)
☐ Other______________ ☐ None of the above

Comments:____

Describe your child's activities outside of the home (hobbies, sports, volunteer activities, etc.):

____

Have your child's leisure time activities increased/decreased over the past 6 months? ☐ Yes ☐ No

Comments:____

CULTURAL/ETHNIC/SPIRITUAL
Ethnic/Racial issues that need to be addressed:____
Religious/Spiritual issues that need to be addressed:____

EDUCATION
Grade in school ______ Ever repeat a grade? _____ Grades/Progress_______________ On schedule to graduate w/peers?______
Suspension_________ Expulsions_________ Truancies_________
Special education classes____
Past and Current Attitude Toward School and Teachers___________________________________
____
____

FAMILY HISTORY
List all of the people who are currently living in the household, also note any relationship problems or strengths:
Age Relationship to child Relationship with child
____
____
____
____

List all of the people who are currently not living in the household, also note any relationship problems or strengths:

Age Relationship to child Relationship with child
____
____

____ Mother only____ Joint Custody ____ Father only ____ Ward of the court

____Other relative–please specify____

____Adopted: If yes, please give age of adoption and important background information:

Frequency of contact between non-custodial parent and your child:__________________________

Have any family members had problems with substance abuse or with mental/emotional health problems? ☐ Yes ☐ No

Comments:____
____

ALCOHOL AND DRUG

Describe what you know about your child's alcohol/tobacco/drug use (including substance, amount used, when started, etc.):_________
____
____
____
____

Have others expressed concerns about your child's substance abuse? ☐ Yes ☐ No

Comments:____
____

Has your child ever experienced any of the following with his/her substance abuse? (Check all that apply):

- ☐ Change in peers
- ☐ Emotional problems
- ☐ Giving up previously enjoyed activities
- ☐ Legal problems
- ☐ Memory lapse after use
- ☐ Increased frequency/quantity of use
- ☐ Mood swings
- ☐ Physical problems
- ☐ Relationship problems
- ☐ School problems
- ☐ Withdrawal symptoms
- ☐ Stealing from family/friends
- ☐ Work problems
- ☐ None of the above

LEGAL

Has your child ever had involvement with the legal system? ☐ Yes ☐ No

Does your child have any current pending legal charges? ☐ Yes ☐ No

Is your child on probation? ☐ Yes ☐ No

Probation Officer:_________________________ Tel(____)_______________

Address____

Has your child ever been in detention/jail? ☐ Yes ☐ No

Does your child have any gang involvement? ☐ Yes ☐ No

Comments:____

____

SOCIAL SUPPORT/PEER INTERACTIONS

Describe views of social support/peer interactions/ability to make and keep friends:

____

____

____

STRENGTHS/ASSETS

Please list any strengths/assets that you view your child having:

____

____

_________________________ _______________

Parent/Guardian signature Date completed

_________________________ _______________

Parent/Guardian signature Date completed

_________________________ _______________

Receiving clinician Date received

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENT, that I/we ______________________________the parents(s)/legal guardians ("client"), do hereby certify to Sorenson's Ranch School, that I/we are true and lawful attorney in-fact for _________________________,("student"), and student is my/our _________________. ("son/daughter") We hereby execute this Power of Attorney for the purpose of providing custodial care, educational, group, and milieu therapy services in connection with Sorenson's Ranch School ("SRS").

Without limiting or qualifying the general Power of Attorney granted and delegated by Client to SRS in the paragraph above, Client specifically grants to SRS the following powers:

1 To provide or obtain all medical, dental, psychiatric treatment, and hospital care, and to authorize a physician to perform any and all procedures that may appear to be medically necessary for the well being of the Student, and release any results, records, or reports on said procedures to SRS medical personnel.

2. To guide and discipline the Student as deemed necessary and reasonable by SRS (but not to include physical punishment.)

3. To physically restrain the Student should he/she become a danger to himself/herself or to anyone else, as deemed necessary by SRS.

4. To allow the Student to participate in all activities.

5. To search the person and personal effects of the Student at any time, and seize and confiscate any items deemed by SRS to be contraband or counterproductive to the Student's successful completion of the Program.

6. To submit for and receive disbursements from any available trust fund, insurance, or government agency the client provides information for.

This Power of Attorney shall be effective from date of arrival, beginning _____________. 20_______ and ending upon the Student's completion of the Program, unless terminated by Sponsor by withdrawing the Student from the Program prior thereto.

I/We have executed this Power of Attorney on this ______day of ________________, 20_____.

___________________________ ______________________________

Father/Guardian Signature Mother/Guardian Signature

____

Signature of Witness

Sorenson's Ranch School
PO Box 440219
Koosharem, UT 84744
435-638-7318

PERMISSION OF RELEASE OF MEDICAL RECORDS

Attention: ______________________________________
Recent Psychiatrist/Doctor Name

____
Hospital

____
Street Address

____
City State Zip

____
Phone Number

Name Of Patient ______________________________________

Date Of Birth ______________________________________

The above named patient has been accepted into Sorenson's Residential treatment Center.
I hereby request the release of his/her records to their facility.

Please include the following:

Current Medical Information
Psychological History

______________________________ ______________________________
Parent/Guardian Signature Parent/Guardian Printed Name

____
Date

SORENSON’S RANCH SIGNATURE FORM

Name Of Student: ____

(Cross out section if you do not wish to sign)

My student has permission to attend any church of his/her choice.

___________________ ____

DATE NAME

Sorenson’s Ranch School has my permission to use name, photos, and audio/video/digital-recordings of my student in brochures or publicity.

___________________ ____

DATE NAME

Sorenson’s Ranch School has my permission to use my name for referrals to prospective parents.

___________________ ____

DATE NAME

I agree that my student may be tested at any time that drugs or alcohol are suspected.

___________________ ____

DATE NAME

I grant permission to staff at SRS to transport my student to and from activities.

___________________ ____

DATE NAME

I grant permission for a staff to dispense medications as prescribed by a Doctor to my Student.

___________________ ____

DATE NAME

I consent to having my student photographed for the secured Parent Services pages on the SRS website for the purpose of providing parents with pictures of activities that their student is involved in.

____

DATE NAME

I consent to allow my child to ride horses while at Sorenson's Ranch School and release Sorenson's Ranch School from any liability if an injury should occur during this activity.

____

DATE NAME

Sorenson's Ranch School
P.O. Box 440219
Koosharem, UT 84744
(435) 638-7318
FAX: (435) 638-1113

PERMISSION TO REQUEST SCHOOL RECORDS

Name of Student ____________________________________D.O.B.:_________________

Most Recent Schools attended:

School Name:___________________________________	Phone:__________________
Street Address:__________________________________	Fax #: __________________
City:______________________________ State: _________________ Zip: ___________	
School Name:___________________________________	Phone:__________________
Street Address:__________________________________	Fax #: __________________
City:______________________________ State: _________________ Zip: ___________	

Requested records include the following:

1. Transcripts
2. Withdrawal grades, including any uncompleted class
3. Health records
4. Immunization Records
5. Any Counseling Information
6. Special Education/Guidance records

I, _________________________________, authorize Sorenson's Ranch School to request and
Parent/Guardian

receive these academic records.

SORENSON'S RANCH SCHOOL
INDIVIDUALIZED LEARNING PLAN

STUDENT NAME:____

EDUCATIONAL HISTORY

Last School Attended:____

Phone:______________________________ Fax:______________________________

Current Grade Level:_________________ Age Appropriate Grade Level:__________

Date of Withdrawal:__________________

Reason for Student Withdrawal:

Suspended Expelled Legal Discipline Normal

Does this student qualify for Special Education? Yes No

Strongest Subjects:____

Weakest Subjects:____

Comments/Past Academic Concerns:____

____

____

____

PERMISSION TO TEST

Student: ____________________________

Sex: M F

Birth date: ___________

Parent/Guardian: ____

Testing is done to ensure the proper placement of your child in the best educational setting for his/her learning capabilities.

Test to be given is WRAT4 (Reading, Mathematics, English).

This test will be administered and scored by a qualified examiner. The test will be given in the student's primary language and will be free of racial and cultural bias.

The testing process can only proceed with your permission. If you have any questions, please contact:

Tina Somers
SPED Teacher
435-638-1167

I give my permission for the testing listed above. I understand that the results of the evaluation will be kept confidential and will be reviewed with me.

____

Parent/Guardian Signature

____

Date

MAIL

Due to the potential harm that certain mail could cause our child or progress, we as legal guardians, (having both legal and physical custody) direct and authorize Sorenson's Ranch School and its staff to monitor all outgoing and incoming mail for ____________________________ whose date of birth is _______________/________.
Student Name

It is understood that Sorenson's Ranch School is operating at our direction, under the authority we have as legal guardians, and as our agents in this behalf.

____
Mother/Guardian

____
Father/Guardian

____
Date

**CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
INCLUDING ALCOHOL OR DRUG TREATMENT INFORMATION
CRIMINAL JUSTICE SYSTEM REFERRAL**

I,____, hereby consent to communication between

SORENSON'S RANCH SCHOOL and

____, regarding
(Court, Probation, Parole, and/or Referring Agency)

____.
Name Of Minor

The purpose of and need for the disclosure is to inform the criminal justice agencies listed above of my attendance and participation and progress in treatment. The extent of the information to be disclosed is my diagnosis, information about my participation or lack of participation in treatment, my cooperation with the program, prognosis, and

____

____

I understand that this consent will remain in effect and cannot be revoked by me until:

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

____ ____
(Other time when consent can be revoked and/or expires)

I also understand that any disclosures made is bound by Part 2 of title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may re-disclose it only in connection with their official duties.

Dated: _______ ___________________________________
(Signature of parent, guardian or authorized
Representative, if required)

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION INCLUDING DRUG AND ALCOHOL TREATMENT TO SORENSON'S RANCH SCHOOL

I,_____________________________________, home address _______________________________________

authorize PREVIOUS TREATMENT PROVIDER,

1)____

2)____

to communicate with and disclose to one another the following information, regarding

Name of Minor____

(*initial each category that applies)*

_____ Student's name and other personal identifying information

_____ Information about my student's status as a patient, including drug and alcohol treatment

_____ Initial evaluation

_____ Assessment results and history

_____ Summary of treatment plan, progress and compliance

_____ Attendance

_____ Date of discharge and discharge status

_____ Discharge plan

_____ Other:____

I understand that my alcohol and 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 cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____ One year after the consent form is signed

_____ Other ____

Dated:_________________________________ _______________________________________

Signature of Parent / Guardian

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
INCLUDING DRUG AND ALCOHOL TREATMENT
TO WELFARE AGENCIES

I, _______________________________, home address____

authorize SORENSON'S RESIDENTIAL TREATMENT CENTER and

____ and ____
(The Local/county Welfare agency and/or its designee) *(The State Welfare agency)*

to disclose to and communicate to one another the following information regarding

____
Name Of Minor

_____ My name and other personal identifying information

_____ Information about my status as a patient, including alcohol and drug treatment

_____ Initial evaluation

_____ Date of admission

_____ Assessment results and history

_____ Summary of treatment plan; progress and compliance

_____ Attendance

_____ Date of discharge and discharge status

_____ Discharge plan

_____ Educational and training related information

_____ Other:____

The purpose of these disclosures is to enable the recipients of the information to evaluate my eligibility or continued eligibility for public assistance and/or medical assistance benefits and to determine my readiness/ability to participate in a work program.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that, except for action already taken, I may rescind this consent at any time. If I do not take back this consent, it expires automatically as follows:

_____ Discontinuance of assistance by the Social Service Agency

_____ One year after the date of the signing of the consent form

_____ Other____

Dated: ___________________ ______________________________________
Signature of parent, guardian, or person authorized
To sign in lieu of client, where required

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
INCLUDING DRUG AND ALCOHOL TREATMENT
TO MANAGED CARE COMPANY AND INSURER

I, _________________________________, home address ______________________________,

authorize SORENSON'S RESIDENTIAL TREATMENT CENTER and my Managed

Care Company, ____ and

my primary insurer, ____

to communicate with and disclose to one another the following information regarding

____
Name of Minor
(**initial each category that applies)*

_____ My name and other personal identifying information

_____ Information about my status as a patient, including drug and alcohol treatment

_____ Initial evaluation

_____ Date of admission

_____ Assessment results and history

_____ Summary of treatment plan, progress and compliance

_____ Attendance

_____ Date of discharge and discharge status

_____ Discharge plan

_____ Other:____

The purpose of these disclosures is to enable the agencies listed above to evaluate my claim for insurance coverage.

I understand that my alcohol and 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 cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____ The date on which my insurance claims for this course of treatment have been completely processed

_____ One year after the consent form is signed

_____ Other ____

Dated:__________

____
Signature of Parent / Guardian

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
INCLUDING DRUG AND ALCOHOL TREATMENT
FROM SORENSON'S RANCH SCHOOL

I, ___________________________________, home address _______________________________,

authorize SORENSON'S RANCH SCHOOL, to release to:

1)____
2)____
to communicate with and disclose to one another the following information, regarding

____
Name of Minor

(*initial each category that applies)*

_____ My name and other personal identifying information

_____ Information about my status as a patient, including drug and alcohol treatment

_____ Initial evaluation

_____ Assessment results and history

_____ Summary of treatment plan, progress and compliance

_____ Attendance

_____ Date of discharge and discharge status

_____ Discharge plan

_____ Other:____

I understand that my alcohol and 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 cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____ One year after the consent form is signed

_____ Other ____

Dated:__________ ______________________________
Signature of Parent /Guardian

SORENSON'S RANCH SCHOOL
(Extracurricular Competitive Sports, including but not limited to Football, Wrestling, Basketball, Gymnastics, etc.)

RECREATIONAL ACTIVITY RELEASE OF LIABILITY, WAIVER OF CLAIMS,
EXPRESS ASSUMPTION OF RISK AND INDEMNITY AGREEMENT
Please read and be certain you understand the implications of signing.
Express Assumption of Risk Associated with Recreational Activities.

I, ____________________________________ do hereby affirm and acknowledge that I have been fully informed of the inherent hazards and risks associated with the football program, including the use of equipment and transportation associated therewith of which I am about to engage in.
Inherent hazards and risks, include but are not limited to:
1. Risk of injury from the activity and equipment utilized is significant including the potential for permanent disability and death.
2. Possible equipment failure and/or malfunction of my own or others' equipment.
3. This activity takes place outdoors and therefore includes risks associated with exposure to elements, excessive heat, hypothermia, etc.
6. Accidents or illness occurring in remote places where there limited access to medical facilities.
7. Fatigue, chill, and/or dizziness, which may diminish my/our reaction time and increase the risk of accident.
*I understand the description of these risks is not complete and that unknown or unanticipated risks may result in injury, illness, or death.
In addition, I authorize Sorenson's Ranch staff to act on my behalf in case of an emergency and agree to be responsible for all expenses incurred with any emergencies.
Please be advised that events will be held off campus and students will be participating in contact football with students from other facilities.
Students will be required to maintain an acceptable level in order to participate as well as follow all Sorenson's Ranch policies and procedures.
Release of Liability, Waiver of Claims and Indemnity Agreement
In consideration for being permitted to participate in the activity (ies) described above and related activities, I hereby agree, acknowledge and appreciate that:
1. I HEREBY RELEASE AND HOLD HARMLESS WITH RESPECT TO ANY AND ALL INJURY, DISABILITY, DEATH, or loss or damage to person or property, WHETHER CAUSED BY NEGLIGENCE OR OTHERWISE, the following named persons or entities, herein referred to as releasees.

SORENSON'S RANCH SCHOOL
410 North 100 East, Koosharem, Utah 84744

2. To release the releasees, their officers, directors, employees, representatives, agents, and volunteers, and vessels from liability and responsibility whatsoever and for any claims or causes of action that I, my estate, heirs, survivors, executors, or assigns may have for personal injury, property damage, or wrongful death arising from the above activities whether caused by active or passive negligence of the releasees or otherwise. By executing this document, I agree to hold the releasees harmless and indemnify them in conjunction with any injury, disability, death, or loss or damage to person or property that may occur as a result of engaging in the above activities.
3. By entering into this Agreement, I am not relying on any oral or written representation or statements made by the releasees, other than what is set forth in this Agreement.
This release shall be binding to the fullest extent permitted by law. If any provision of this release is found to be unenforceable, the remaining terms shall be enforceable.
I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, AND I FULLY UNDERSTAND ITS TERMS, AND UNDERSTAND THAT I HAVE GIVEN UP LEGAL RIGHTS BY SIGNING IT, AND I SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

FOR PARTICIPANTS OF MINORITY AGE: This is to certify that I, as Parent, Guardian, Temporary Guardian with legal responsibility for this participant, do consent and agree not only to his/her release of all Releasees, but also to release and indemnify the Releasees from any and all liabilities incident to his/her involvement in these programs for myself, my heirs, assigns, and next of kin.

S/__________________________________ ____ _____________

Signature of Parent or adult legal Guardian Name of Parent or adult legal Guardian (Please Print) Date
If participant is a Minor, and by their signature, they on my behalf release all claims that both they and I have

______________________________________ ___________
Name of Minor (Please Print) Date

P. O. Box 440219, Koosharem, Utah 84744
Phone: 435-638-7318 or 800-455-4590
Fax: 435-638-7582

CONSENT OF RELEASE TO INSURANCE PROVIDER

I, ______________________, request and authorize the clinical representative of Sorenson's Ranch School, Koosharem, Utah, to disclose a Copy of application, treatment plan information, individual and group therapy and counseling notes, progress notes, psychiatric assessment, and psychologist assessment, and medication assessment and application to (Name/title Organization to which disclosure is made)_____________ for ___________________________(Name of student). This disclosure is made to qualify the above patient to meet requirements of coverage and to obtain program evaluation while attending Sorenson's Ranch School.

This consent is subject to written revocation at any time except to the extent that the program that is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon the completion of documented discharge of patient.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

____

Dated Signature of parent/guardian

(Complete ONLY if you have residential treatment insurance benefits) Please notify Accounts Receivable so they can start working on Prior Authorization.

Sorenson's Ranch School

ASSIGNMENT OF INSURANCE BENEFITS

You must pre-authorize coverage before student arrives at SRS

INSURANCE COMPANY____

ADDRESS OF INS COMPANY____

TELEPHONE NUMBER OF INSURANCE COMPANY_______________________________

PREAPPROVAL NUMBER____________________CASE MANAGER___________________

GROUP NUMBER__________________________POLICY NUMBER___________________

INSURED'S NAME_______________________INSURED'S SS #_______________________

INSURED'S DATE OF BIRTH ________________________

INSURED'S EMPLOYER____

For the purposes of paying all or part of monies owing to SORENSON'S RANCH SCHOOL for services it has or will render to the above patient, the undersigned hereby irrevocably assigns to SORENSON'S RANCH SCHOOL any benefit payments payable for the benefit of said patient by the above insurance company or companies and all rights and interest in said policy but only to the extent necessary to pay SORENSON'S RANCH SCHOOL in full. Undersigned agrees to be liable to pay the full amount of all monies billed by SORENSON'S RANCH SCHOOL. As a result of rendering services to the above mentioned patient liability will be reduced by the amount of benefit payments received hereafter. Undersigned understands that the nature of patient's disability may be such that no benefit payments will be payable under the policy specified above. Any monies owing by the undersigned under the terms of this Agreement shall be paid in full within 30 days after billing by SORENSON'S RANCH SCHOOL, unless other arrangements have been made. In the event that collection efforts are undertaken by SORENSON'S RANCH SCHOOL to enforce any of the terms of the Agreement, all expenses associated therewith, including reasonable attorney's fees, will be paid by the undersigned.

____________________________ ____

DATE POLICY HOLDER AND/OR PARENT SIGNATURE

***Please attach a photocopy of the student's medical insurance card.*
*We must have this in order to file insurance claims.***

INDIVIDUAL TREATMENT PLAN INPUT

STUDENT:

PARENT: DATE:

INDIVIDUAL CARE AND TREATMENT PLANS INCLUDING EDUCATION PLANS are made for each student. Social academic, emotional, physical goals are to be included. Please send your input:

1. Goal in life I desire for my student:

2. Goal upon termination at the ranch:

3. Objectives to work toward or problems of my student:

Copies of Monthly Progress Reports/Access to Student Webpage to be sent to the following:

Name:____ **Email Address**:___________________________

Address:____Phone:______________________

City:__________________________State:_______Zip:________Fax:________________________

Relation to Student:____
(caseworker, probation officer, educational consultant)

Name:____ **Email Address**:___________________________

Address:____Phone:______________________

City:__________________________State:_______Zip:________Fax:________________________

Relation to Student:____
(caseworker, probation officer, educational consultant)

Name:____ **Email Address**:___________________________

Address:____Phone:______________________

City:__________________________State:_______Zip:________Fax:________________________

Relation to Student:____
(caseworker, probation officer, educational consultant)

Name:____ **Email Address**:___________________________

Address:____Phone:______________________

City:__________________________State:_______Zip:________Fax:________________________

Relation to Student:____
(caseworker, probation officer, educational consultant)

Name:____ **Email Address**:___________________________

Address:____Phone:______________________

City:__________________________State:_______Zip:________Fax:________________________

Relation to Student:____
(caseworker, probation officer, educational consultant)

Students May Have Contact With the Following:

Please complete this list with the information on the people that your student is allowed to have contact with. Please understand that our phone policies and privileges apply regardless.

Name:________________________________Email Address:____

Address: ____Phone: _____________________

City: _________________________State: _______Zip: ________Fax:_______________________

Relation to Student: ____
(parent, grandparent, guardian, caseworker, probation officer, etc.)

Students may have letters? Yes No Student may have phone calls? Yes No

Name:_______________________________Email Address:____

Address: ____Phone: _____________________

City: _________________________State: _______Zip: ________Fax: _______________________

Relation to Student: ____
(parent, grandparent, guardian, caseworker, probation officer, etc.)

Students may have letters?: Yes No Student may have phone calls? Yes No

Name: ________________________________ Email Address: ____

Address: ____Phone: _____________________

City: _________________________State: _______Zip: ________Fax: _______________________

Relation to Student: ____
(parent, grandparent, guardian, caseworker, probation officer, etc.)

Students may have letters? Yes No Student may have phone calls? Yes No

Name:_________________________________Email Address:____

Address: ____Phone: _____________________

City: _________________________State: _______Zip: ________Fax: _______________________

Relation to Student: ____
(parent, grandparent, guardian, caseworker, probation officer, etc.)

Students may have letters? Yes No Student may have phone calls? Yes No

January 1, 2014

RE: Interstate Compact Agreement

Dear Parent or Guardian:

Federal Law requires that children cannot be placed into the care of an agency across state lines without the approval of the Interstate Compact Authorities in each state. This is intended to assure that children are placed into licensed, safe placements and that the state laws in the sending and receiving states are followed. Even parent placements are regulated by this compact agreement, unless placing directly with a relative.

I have enclosed a copy of the Interstate Compact Placement Request. Please follow these steps when completing:

1. Complete Section I of the Interstate Compact Placement Request with the vital information.
2. Sign the request in Section III where the X indicates

.

After you have completed the Interstate Compact Placement Request then return it to Sorenson's. We will then forward it to the appropriate state for completion.

It is imperative that these forms be completed and returned to Sorenson's immediately.

If you have any questions concerning this please contact my office at (435) 638-7318.

Sincerely yours,

Linda Nebeker

ICPC 100A

One form per child
Please type

INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN REQUEST

TO: Scott Hodges-Division of Family Service
195 North 1950 West
Salt Lake City Utah 84116

FROM:

SECTION I - IDENTIFYING DATA

Notice is given of intent to place - Name of Child:

Ethnicity: Hispanic Origin: ☐ Yes ☐ No ☐ Unable to determine/unknown

Social Security Number:

ICWA Eligible ☐ Yes ☐ No

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian/ Other Pacific Islander ☐ Black or African American ☐ White

Sex: | Date of Birth | Title IV-E determination ☐ Yes ☐ No ☐ Pending

Name of Mother: | Name of Father:

Name of Agency or Person Responsible for Planning for Child: | Phone:

Address:

Name of Agency or Person Financially Responsible for Child: | Phone:

Address:

SECTION II - PLACEMENT INFORMATION

Name of Person(s) or Facility Child is to be placed with:
Sorenson's Ranch School

Soc Sec # (optional):
Soc Sec # (optional):

Address:
P O Box 440219, 410 North 100 East Koosharem UT 84744

Phone:
435-638-7318

Type of Care Requested:

☐ Foster Family Home
☐ Group Home Care
☐ Child Caring Institution
X Residential Treatment Center
☐ Institutional Care-Article VI, Adjudicated Delinquent
☐ Parent
☐ Relative (Not Parent)
Relationship: _______________
____
☐ Other: _______________

☐ ADOPTION
☐IV-E Subsidy
☐Non IV-E Subsidy
To Be Finalized In:
☐ Sending State
☐ Receiving State

Current Legal Status of Child:

☐ Sending Agency Custody/Guardianship
X Parent Relative Custody/Guardianship
☐ Court Jurisdiction Only
☐ Protective Supervision
☐ Parental Rights Terminated-Right to Place for Adoption
☐ Unaccompanied Refugee Minor
☐ Other:

SECTION III - SERVICES REQUESTED

Initial Report Requested (if applicable):
☐ Parent Home Study
☐ Relative Home Study
☐ Adoptive Home Study
☐ Foster Home Study

Supervisory Services Requested:
☐ Request Receiving State to Arrange Supervision
☐ Another Agency Agreed to Supervise
X Sending Agency to Supervise

Supervisory Reports Requested:
☐ Quarterly
☐ Semi-Annually
☐ Upon Request
☐ Other:

Name and Address of Supervising Agency in Receiving State:

Enclosed: ☐ Child's Social History ☐ Court Order ☐ Financial/Medical Plan ☐ Other Enclosures ☐ Home Study of Placement Resource ☐ ICWA Enclosure ☐ IV-E Eligibility Documentation

Signature of Sending Agency or Person: | Date:

Signature of Sending State Compact Administrator, Deputy or Alternate: | Date:

SECTION IV - ACTION BY RECEIVING STATE PURSUANT TO ARTICLE III(d) of ICPC

☐ Placement may be made ☐ Placement shall not be made

REMARKS:

Signature of Receiving State Compact Administrator, Deputy or Alternate: | Date:

Sorenson's Ranch School
P.O. Box 440219
Koosharem, Utah 84744
PHONE (435) 638-7318 /FAX (435) 638-7582

Dear Parents,

Sorenson's Ranch School is able to accept **Visa, MasterCard, American Express,** or **Discover** for payment. This method of payment may be beneficial to those who earn extra credit or miles for every dollar they spend.

All credit cards are debited on or about the 25th of each month automatically for the next month. Please fill out the needed information, sign the authorization, and mail back to the address at the bottom of the letterhead. An itemized bill will be sent to you each month with all charges and credits that were applied.

If you have any questions please feel free to contact me.

Sincerely,

Mindy Talbot

CREDIT CARD AUTHORIZATION
(please print)

I ______________________________________ hereby give my permission for Sorenson's

Ranch School to debit my credit card monthly tuition and all other monthly charges for my

Child: ____.

Credit Card Number ____

Exp. Date ___________________ CVC code: _________________

Signature ________________________________ Date: _______________

Please list the billing address EXACTLY as it appears on your credit card statement.

Address: ____

City: ____________________________State: ______________Zip: ___________

Day Phone: ______________________Evening Phone: _________________________

Sorenson ′s Ranch School
P.O. Box 440219
Koosharem, UT 84744
PHONE (435) 638-7318/ FAX (435) 638-7582

Dear Parents,

Sorenson's Ranch School **REQUIRES** that you provide a credit/debit card account for Medical Co-Pays and the Pharmacy to use for billing. Please fill out and sign the form below and return with completed Admissions Packet. All prescriptions co-pays will be billed to this card. Medical co-pays will only be charged in the event that the service provider requires one.

If you have any questions please feel free to contact me.

Sincerely,

Mindy Talbot

CREDIT CARD AUTHORIZATION
(Please Print)

I ______________________________________ hereby give my permission for Sorenson's Ranch School Provider's

to debit my credit card Medical Co-Pays and Prescriptions monthly charges for my child: ____________________.

Credit Card Number ____

Exp. Date: __________________________ CVC code: _______________________________________

Please list the billing address EXACTLY as it appears on your credit card statement.

Address: ____ City: ______________________________

State: _______ Zip: ____________ Day Phone: ___________________ Evening Phone: _____________________

TERMS OF THE AGREEMENT:
By signing this Agreement, I agree to be financially responsible for the payment of all prescriptions, other medications, supplies, and pharmacy service fees, including but not limited to delivery and administrative fees, provided to Customer. I agree to provide the pharmacy with any and all current information regarding prescription insurance coverage or medical assistance programs under which Customer is eligible. If Customer's insurance company or medical assistance program does not pay the entire balance of an item, the balance due will be charged to this account. I agree to allow the pharmacy to retain a copy of my credit card on file. Credit card charges are processed when service is rendered. I agree to notify the pharmacy of any changes to my credit card, i.e. lost, stolen, new card numbers, expirations date changes, etc.

Print Name: ____

Signature: ____ Date: ________________________