



WHITE EARTH OSHKI MANIDOO CENTER

1741 15th Street N.W.,
 Bemidji, MN 56601
 Office: 218-751-6553
 Fax: 218-751-1846

ADMISSION FACE SHEET/CLIENT DEMOGRAPHICS

CLIENT AND FAMILY INFORMATION

check if release of information obtained from referring entity

| | | | | | |
|-------------------------------------------------------------------------------------------------------|---|------------------------------------|--------------------|-----------------|----------|
| Admission Date: | | Admission Time: | | Discharge Date: | |
| Full Name: | | | | Nickname(s): | |
| SSN: | | | | | |
| Age: | | Date of Birth: | | Place of Birth: | |
| Gender: | | Race or Cultural Heritage: | | | |
| Tribal Affiliation: | | | | | Enrolled |
| Descendant | | Recognized member of the community | | Enrollment # | |
| Languages the resident speaks and writes: | | English | | Ojibwe | |
| Spiritual or religious affiliation of the resident and the client's family: | | | | | |
| Name, address, and telephone number of parents, legal guardian, caregiver, advocate including agency: | | | | | |
| Last Known Address: | | | Permanent Address: | | |
| | | | | | |
| Phone 1 | | | | Phone 2 | |
| Message at this number ok? | | Yes | | No | |
| Message at this number ok? | X | Yes | | No | |

REFERRING AGENCY INFORMATION

| | | | | | |
|-----------------------------------------------------------------|--|--|-----------|--|--|
| Person Making Referral/ Financially Responsible Agency:: | | | | | |
| Agency/County/Tribal Authority: | | | | | |
| Mailing Address: | | | | | |
| Phone #1: | | | Phone #2: | | |
| E-Mail Address: | | | Fax #: | | |

Authorized length of stay (if indicated):

| | | | | | | |
|------------|---|-------------|--|--------------|--|-------------------|
| 30-60 days | X | 61-120 days | | 121-180 days | | Other: _____ days |
|------------|---|-------------|--|--------------|--|-------------------|

Cost of Care Funding Source/Insurance Information

| | | | | | |
|---|-------------------------|---|--------------------|--|---------------------------|
| X | CCDTF | X | Medical Assistance | | Managed Care Organization |
| | County/Tribal/IHS Funds | | Private Insurance | | Other: |

***Authorization for payment of services will be verified prior to admission.**

HEALTH INSURANCE INFORMATION

| | | | | | | |
|---------------------|---|-----|--|----|--------------------|--|
| Medical Assistance? | X | Yes | | No | Policy # | |
| Private Insurance? | | Yes | | No | Policy # | |
| Insurance Name | | | | | Policy Holder Name | |

DESCRIPTION OF STRENGTHS & PRESENTING PROBLEMS

Description of assets & strengths of the client & related information from the resident's family and concerned persons in the client's life

| |
|--|
| |
|--|

| | | | |
|------------------------------------------------------------------------------------------------|------------------|-------------------|---------------------------------------------------|
| Circumstances Leading to Admission: | | | |
| | | | |
| Substance Use Disorder Concerns/ Current Diagnosis | | | |
| | | | |
| Medical Problems/Physical Needs/ Physical Conditions/Special Medical Care Needed: | | | |
| | | | |
| Medications/Allergies | | | |
| | | | |
| Mental Health Concerns/Current Diagnosis(es)/Emotional Needs: | | | |
| | | | |
| Delinquency concerns: | | | |
| | | | |
| Safety concerns including assaultive behavior and victimization concerns: | | | |
| | | | |
| Cultural Needs: | | | |
| | | | |
| Educational Needs: See school forms | | | |
| Educational Program (most recent)/Home School District (if different): See school forms | | | |
| Previous services/Placement history (community based & residential) | | | |
| Name of Facility/Agency: | Type of Service: | Dates of Service: | Progress/Benefits to Client/Reason for Discharge: |
| | | | |
| | | | |
| IDENTIFIED GOALS/SERVICES/IMMEDIATE NEEDS: | | | |
| Anticipated living arrangement after discharge: | | | |
| | | | |
| Assessment /Outside agency service needs | | | |
| | | | |
| Family goals/Family support needs | | | |
| | | | |

**Oshki Manidoo Center/Women's Wellbriety
EMERGENCY ACTION PLAN**

Client Name: _____ DOB: _____ Admit Date: _____

| Guardian/Home Address/Phone | Parent/Family Name/Address/Phone | Placing Authority Contact Information |
|-----------------------------------|-----------------------------------------------|---------------------------------------|
| | | |
| | | |
| | | |
| Social Worker Contact Information | Probation Contact Information | Other Contact Information |
| | | |
| | | |
| Diagnosis(es) | Medications | Medical Conditions |
| | | |
| | | |
| Insurance Information | Allergies | Physical description |
| | | |
| | | |
| | | |
| Names & Ages of children | Other Vulnerabilities/Identified Safety Risks | Effective Intervention |
| | | |
| | | |
| | | |
| | | |

- | | | |
|----------------------------------------------------------------------------------------------------------------------|--|--|
| Emergency Action Plan Protocol | | |
| 1.) Call 911 for medical emergency | | |
| 2.) Inform all contacts listed above as soon as possible of the emergency even including emergency service personnel | | |
| 3.) Follow policy/protocol for emergency even (medical emergency, run/missing. Psychaitric crisis) | | |
| 4.) Complete incident report within 24 hours and forward to Supervisor - Clinical Manager | | |
| 5.) Make follow-up contacts listed above after emergency has handled | | |

Additional Information: _____



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 1741 154th St. N.W.
 Bemidji, MN 56601
 Phone: 218-751-6553 Fax: 218-751-1846
 Email: oshkimanidooctr@whiteearth.com
REFERRAL FOR SERVICES

REFERRING AGENCY INFORMATION

| | | | |
|---------------------------------|--|----------|--|
| Person Making Referral: | | Phone #: | |
| Agency/County/Tribal Authority: | | | |
| Mailing Address: | | | |
| Fax #: | | Email: | |

REASON FOR REFERRAL

| | | | |
|--------------------------|-------------------------------------------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | Rule 25 Assessment Indicates Need for Residential Treatment | Date of Assessment: | |
| <input type="checkbox"/> | Rule 25 Assessment Requested/Attached | <input type="checkbox"/> | Rule 25 Assessment Needed |

Legal authority for client placement:(check all that apply)

| | | | |
|--------------------------|----------------------------------------------------------|--------------------------|--------------|
| <input type="checkbox"/> | Voluntary Placement | <input type="checkbox"/> | CHIPS (ICW) |
| <input type="checkbox"/> | Court Ordered | <input type="checkbox"/> | Probation |
| <input type="checkbox"/> | Civil Commitment: *Please attach Civil Commitment Order. | <input type="checkbox"/> | Other: _____ |

POTENTIAL CLIENT IDENTIFYING INFORMATION (*Must have release of information to complete this section)

| | | | | | | | | | | | | | | | | | | |
|-------------------------------------------------|--------------------------|---|--------------------------|--------------|-----|--------------------------|-----------|--------------------------|-----|--------------------------|----|-----------------|--------------------------|-----|--------------------------|----|-------|--------------------------|
| check if release of information obtained | | | | | | | | | | | | | | | | | | |
| Full Name: | | | | Nickname(s): | | | | Date of Birth: | | | | | | | | | | |
| Gender: | <input type="checkbox"/> | M | <input type="checkbox"/> | F | Age | <input type="checkbox"/> | Pregnant? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Minor Children? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Ages: | <input type="checkbox"/> |
| Last Known Address: | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |

| | | | | | |
|------------------------------|--|--------------|--|--------------|--|
| Referral Received By: | | Date: | | Time: | |
|------------------------------|--|--------------|--|--------------|--|

FOLLOW-UP TO REFERRAL: Documentation of follow-up activities: (pre-admission interview, admission arrangements, client not admitted-give reason, releases, records requested, intake date scheduled, date intake occurred – date & sign each entry).



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OMC Privacy Statement for Patients and Relatives

| | | | | | |
|---------------------|--|-------------|--|--------------------|--|
| Client Name: | | DOB: | | Admit Date: | |
|---------------------|--|-------------|--|--------------------|--|

Federal Regulations CFR 42, Part 2, Confidentiality of Alcohol and Drug Abuse Records and Minnesota Data Privacy Act M.S. 15-1653 require OMC to keep all information about you strictly private.

Information we request or maintain will be used to:

1. Evaluate your service need.
2. Collect payment for your treatment.
3. Meet county, tribal, state or federal statistical requirements. (Your name is not used when reports are filed.)
4. Share information with a service provider with whom we have qualified service agreements and release of information.
5. Share information about the type, amount, dates, costs, outcome and evaluation with program staff who need to keep records or provide services.

Exceptions to Disclosure

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

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

You may see all information about you according to the "client request to see records" policy. If you think documented information is incorrect, your written explanation will be added to your client record.

Client/ Legal Guardian/Authorized Representative Signature

Date

OMC Staff Signature

Date

10/12/15



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OMC.WWC CONFIDENTIALITY AGREEMENT

White Earth Oshki Manidoo Center is a culturally specific treatment program for Native and non-Native American youth, adult women, and their children addressing substance abuse and mental health issues. Access to sensitive and confidential information regarding clients, Oshki Manidoo Center, Women’s Wellbriety Center and White Earth Reservation Tribal Council practices, and policies and procedures is apparent. Identification of clients, activities, written and verbal communications is strictly **confidential**. Under no circumstances is confidential information to be discussed or shared with others.

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

Purpose of agreement: _____

(i.e. client, event, speaker, consultant, cultural, family member)

Print Name

Title

Client/Legal Guardian/Authorized Rep. Signature

Date

OMC/WWC Staff Signature

Date

10/2/15



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OMC.WWC Consent to Treatment, Drug Testing, and Transportation

| | | | | | |
|-------------------------------------------------------------|--|-----------------|--|--------------------|--|
| Client Name: | | DOB: | | Admit Date: | |
| Phone Numbers where you authorize us to contact you: | | | | | |
| Phone 1: | | Phone 2: | | | |

CONSENT TO TREAT FOR DRUG AND ALCOHOL COUNSELING

By signing below, I consent to treatment and counseling provided by the Oshki Manidoo Center/Women’s Wellbriety counselor/s for myself/my child/legal dependent. I understand that anything I say will be kept in strict confidentiality and will not be shared to anyone outside the treatment program without my signed consent. Information may be shared with other members of the treatment team to assist in your therapy and/or treatment when necessary. I understand that OMC.WWC staff including my Counselor are a mandated reporters and are required to report any suspicion of child abuse, elder abuse and are subject to duty to warn. I understand that I have a right to participate in planning the goals, methods and estimated length of my treatment and will be asked to be involved in the duration of my plan.

| | |
|------------------------------------------|-------|
| _____ | _____ |
| Client Signature | Date |
| _____ | _____ |
| Legal Guardian/Authorized Representative | Date |

INFORMED CONSENT FOR DRUG TESTING

I, as legal guardian/authorized representative of _____, give my consent to complete UA/saliva drug testing on myself/my child/legal dependent. if warranted per OMC.WWC Drug Testing Policy. Positive screens will be validated by Redwood Biotech.


| | |
|------------------------------------------|-------|
| _____ | _____ |
| Client Signature | Date |
| _____ | _____ |
| Legal Guardian/Authorized Representative | Date |

CONSENT TO PROVIDE TRANSPORTATION

I, as legal guardian/authorized representative of _____, give my consent to OMC/WWC to provide transportation for myself/my child/legal dependent.

| | |
|------------------------------------------|-------|
| _____ | _____ |
| Client Signature | Date |
| _____ | _____ |
| Legal Guardian/Authorized Representative | Date |

10/2/15

| | |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <p>WHITE EARTH OSHKI MANIDOO CENTER 1741 15th Street N.W., Bemidji, MN 56601 Office: 218-751-6553 Fax: 218-751-1846</p> <p>RELEASE OF INFORMATION</p> |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| | | | |
|--------------------|-------------|-------------------|--|
| Client Name | DOB: | Admit Date | |
|--------------------|-------------|-------------------|--|

| | |
|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| I authorize: (agency/contact name, address, phone, fax) | To release or exchange health information with: |
| | WHITE EARTH OSHKI MANIDOO CENTER 1741 15 th Street N.W., Bemidji, MN 56601 |
| ph | fx |

| | | | |
|------------------------------------------------------------|--------|-----|--|
| Specific Dates/Years of information to be released: | From : | To: | |
|------------------------------------------------------------|--------|-----|--|

Information to be released or exchanged (specific information checked):

| | | |
|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| Substance Use: Rule 25 Assessment, SUD Comprehensive Assessment & Assessment Summary | Mental Health: Diagnostic Assessment, Psychological/Psychiatric Evaluation/Testing | Medical Records: Medical history, Physical exam, Admit/Discharge Summary, Medications, Immunizations |
| Substance Abuse Treatment Plans, Progress Reports, Discharge Summary & Recommendations | Mental Health: Treatment plans, Progress Reports, Discharge Summary & Recommendations | Correction/probation/Court info./order/Civil Commitment Order |
| Drug Testing | Social service Agency Information (social history, case plan) | Education information (academic, IEP, transcripts) |
| Billing Information | Other (specify): | |

The information is necessary for:

| | | |
|---------------------------------|-------------------------------------------|-----------------------------|
| Assessment & Diagnosis | Legal | Insurance/Financial/Billing |
| Service Coordination & Delivery | Education Purposes | Client's Request |
| Family Member Request: | (family member & relationship to client:) | |
| Other (Specify) | | |

PLEASE NOTE THE FOLLOWING: I understand that by signing this form,

- I am requesting that the health information specified above be sent to the third party named above.
- I have the right to revoke this authorization at any time giving written notice to Oshki Manidoo Center. I understand that the revocation will not apply to information that has already been released in response to this authorization Oshki Manidoo Center cannot prevent the re-disclose of records release as a result of this request and that after release from Oshki Manidoo Center, the records may not be subject to privacy rule protections.
- I understand that if the organization named above is a health care provider, they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. If I choose not to sign this form and the organization named above is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.
- This authorization will permit two-way telephone communication and exchange of information by electronic methods.
- I am entitled to a copy of this authorization once I have signed and I may review/request copies of information disclosed.
- A photograph or facsimile of this authorization is as effective as the original.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

| | | |
|-------|-----------------|--|
| Date: | Specific Event: | |
|-------|-----------------|--|

| | |
|-----------------------------------------------------|-------|
| Client Signature: | Date: |
| Or legally Authorized Representative Signature: | Date: |
| Parent/Guardian Signature (if different from above) | Date: |
| Client is unable to give consent because: | |

6/1/15



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OMC.WWC Consent to Administer Influenza and HPV Vaccines

| | | | | | |
|---------------------|--|-------------|--|--------------------|--|
| Client Name: | | DOB: | | Admit Date: | |
|---------------------|--|-------------|--|--------------------|--|

CONSENT TO ADMINISTER INFLUENZA VACCINE

I, _____, client/parent/guardian, authorize OMC.WWC to vaccinate
_____ for influenza.

Client/ Legal Guardian/Authorized Representative Signature

Date

Telephone Authorization Given To

Date

CONSENT TO ADMINISTER HPV VACCINE

I, _____, client/parent/guardian, authorize OMC.WWC to vaccinate
_____ for HPV.


Client/ Legal Guardian/Authorized Representative Signature

Date

Telephone Authorization Given To

Date

10/2/15

| | | | | | |
|-----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------|--|
|  | | WHITE EARTH OSHKI MANIDOO CENTER 1741 15 th Street N.W., Bemidji, MN 56601 Office: 218-751-6553 Fax: 218-751-1846 | | | |
| | | OMC.WWC Cultural Activities Consent & Media Release | | | |
| Client Name | | DOB | | Date of Admission | |

| Cultural/Spiritual Activities Consent | |
|---------------------------------------------------------------------------------------------------------------|-------------|
| I give my consent for the above client to attend and participate in Cultural/Spiritual Activities of OMC/WWC. | |
| | |
| Legal Guardian/Authorized Representative Signature | Date |

| Media Release (check all that apply) | |
|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | I give OMC.WWC my permission to take my (and my children, if any) photograph for identification use within this program. I understand my photo will not be shared with any other programs or used outside of this program for any reason |
| | Also , I give OMC.WWC my permission to use photos taken of me (and my children, if any) for the purposes of representing client participation in groups or activities at OMC.WWC. These photos may be placed in advertisements or brochures (paper and/or electronic) that represent OMC.WWC. I understand that persons in the greater community may recognize my participation in substance use disorder treatment. |
| In the event that OMC must initiate restrictive procedures: | |
| | I wish to be notified EACH TIME of the use of restrictive procedures with my child |
| | I wish to be notified WEEKLY of the use of restrictive procedures with my child. |
| | |
| Legal Guardian/Authorized Representative Signature | Date |

6/8/15



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OMC.WWC Client Contact List

| | | | | | | | |
|--------------------|--|------------|--|-----------------|--|--------------------------|--|
| Client Name | | DOB | | Client # | | Date of Admission | |
|--------------------|--|------------|--|-----------------|--|--------------------------|--|

APPROVED CONTACT LIST

| | | | | | | |
|-------------------------------|--|-----------------|------------|--|-----------|--|
| 1. Name | | Phone # | | | | |
| Relationship to Client | | Mail OK? | Yes | | No | |
| 2. Name | | Phone # | | | | |
| Relationship to Client | | Mail OK? | Yes | | No | |
| 3. Name | | Phone # | | | | |
| Relationship to Client | | Mail OK? | Yes | | No | |
| 4. Name | | Phone # | | | | |
| Relationship to Client | | Mail OK? | Yes | | No | |

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

| | | | | | | |
|-------------------------------|--|----------------------------------------------------|------------|--|-----------|--|
| 1. Name | | Phone # | | | | |
| Relationship to Client | | Is there a legal no contact order in place? | Yes | | No | |
| 2. Name | | Phone # | | | | |
| Relationship to Client | | Is there a legal no contact order in place? | Yes | | No | |
| 3. Name | | Phone # | | | | |
| Relationship to Client | | Is there a legal no contact order in place? | Yes | | No | |

EMERGENCY CONTACT INFORMATION

| | | | | | | |
|-------------------------------|--|-----------------|------------|--|-----------|--|
| 1. Name | | Phone # | | | | |
| Relationship to Client | | Mail OK? | Yes | | No | |
| 2. Name | | Phone # | | | | |
| Relationship to Client | | Mail OK? | Yes | | No | |
| 3. Name | | Phone # | | | | |
| Relationship to Client | | Mail OK? | Yes | | No | |
| 4. Name | | Phone # | | | | |
| Relationship to Client | | Mail OK? | Yes | | No | |

10/2/15

Cultural Pre-Screen

Client Name: _____ DOB: _____ Admit Date: _____

How do you identify yourself in the following?

What Race/Ethnicity do you identify with? _____

What Spirituality/Religion do you identify with? _____

Does the Traditional Native culture of your region influence your life? _____

What Traditional Languages do you identify with? _____

Do you have any dietary restrictions? If so, what? _____

How important is it to you to have staff who are from the same culture? _____

Please explain: _____

Is it easier for you to relate to female or male peers? _____

Is it easier for you to relate to female or male staff? _____

Do you tend to feel unsafe with others of a particular culture or gender? _____

What would help you to feel comfortable and accepted as you begin this program? _____

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

If so, where are you enrolled? _____

If not, are you a descendent? Yes/No

Are you part of a Traditional Community? Yes/No If so, what community? _____

What do you know of the Traditional Clan System? _____

Do you have a Clan? Yes/No Do you know what it is? Yes/No Do you have a Traditional Name? Yes/No

Have you ever been to any type of Ceremony? Yes/No If yes, what type of ceremony? _____

If you have a First Nations background, would you like to know more about its traditions? Yes/No

What would you like to know more about? _____

What will help you feel comfortable in this program? _____

What are your personal learning expectations of Traditional Culture during your stay at Oshki Manidoo Center?
