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		Other:						
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 911for medical emergency
2.) Inform all contacts listed above as soon as possible of the emergency even including emerency 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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Email: oshkimanidoocenter@whiteearth.com

REFERRAL FOR SERVICES

REFERRING AGENCY INFORMATION			
Person Making Referral:		Phone #:	
Agency/County/Tribal Authority:			
Mailing Address:			
Fax #:		Email:	

REASON FOR REFERRAL			
	Rule 25 Assessment Indicates Need for Residential Treatment	Date of Assessment:	
	Rule 25 Assessment Requested/Attached		Rule 25 Assessment Needed

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

	Voluntary Placement		CHIPS (ICW)
	Court Ordered		Probation
	Civil Commitment: *Please attach Civil Commitment Order.		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:		M		F	Age		Pregnant?		Yes		No	Minor Children?		Yes		No	Ages:	

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).

5/5/15

	**WHITE EARTH OSHKI MANIDOO CENTER** 1741 15th Street N.W., Bemidji, MN 56601 Office: 218-751-6553 Fax: 218-751-1846 **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

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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

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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

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OMC MEDICAL CONSENT

Client Name		**DOB**		**Date of Admission**	

I hereby authorize and give my consent to any dental, optical, medical care or surgical procedures to be performed on my child, (see client name above) while at the Oshki Manidoo Center (OMC) when in the opinion of an attending, duly qualified physician or nurse practitioner, said services deemed necessary or advisable. I consent to administration of whatever anesthetics are advisable or deemed necessary. I also authorize and give my consent to administration of meds prescribed by a licensed physician or nurse practitioner to my child at OMC if deemed necessary or advisable. In addition, I authorize for the administrations of any vaccines needed for my child required by the MN Legislation Statute 121A.15. I have received written information on these vaccines.

It is my understanding that OMC staff will informed me as soon as possible if a medical emergency occurs and attempt to obtain my permission for any surgical procedures.

_____ _____
Legal Guardian/Authorized Representative Signature Date

I further authorize the above approved Medical, Dental or Optical care provider to release information regarding this care of my child to OMC following completion of these care services.

_____ _____
Legal Guardian/Authorized Representative Signature Date

I hereby authorize the Response Personnel to provide authorizing signature when I am unable to be reached and emergency hospital care is warranted.

_____ _____
Legal Guardian/Authorized Representative Signature Date

I hereby authorize the above approved medical, dental or optical care provider to file claims to our health insurance payments made directly to the provider and any balance owed after insurance has processed to be billed directly to the parents for payment.

_____ _____
Legal Guardian/Authorized Representative Signature Date

I also authorize and give my consent to administer over the counter medications for minor illness to my child at OMC when deemed necessary.

_____ _____
Legal Guardian/Authorized Representative Signature Date

Part I: OMC cannot accept financial responsibility for children in our care who need medical services. To ensure that our vendors receive payment, please sign off on the following statement: "When a child is placed without adequate medical insurance (or whose medical insurance is canceled/terminated while at OMC and who has no Medical Assistance as back-up, our vendors will be instructed to directly bill the financially responsible agency/county/parent."

_____ _____
Legal Guardian/Authorized Representative Signature Date

Part II: The parent and/or financially responsible agency/county has the option to arrange for all medical, dental or vision services and provide transportation to and from appointments while the child is a resident of OMC.

_____ _____
Legal Guardian/Authorized Representative Signature Date

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RELEASE OF INFORMATION

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 15th 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:			

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OMC YOUTH RESTRICTIVE PROCEDURES NOTIFICATION

Client Name		**DOB**		**Date of Admission**	

I understand that the Oshki Manidoo Center utilizes the Crisis Prevention Intervention (CPI) approach and OMC Behavioral Intervention System. The CPI core philosophy is providing Care, Welfare, Safety and Security for clients and staff during crisis moments. Physical intervention is the last resort and is limited to emergency situations involving the likelihood that the youth will physically harm or is physically harming self and/or others.

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**

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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

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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**

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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**	

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?

_____