Heritage Schools, Inc.
ADMISSIONS CHECKLIST

All of the following documents are needed prior to admission. If you have any questions, please contact the Admissions Assistant, Carol Dean, at (800) 433-9413, ext. 264.

_____ **Application (pp. 1 a, b, c, d, e, f, g, h, i, j, k, l) r ATTENTION r These 12 pages must be filled out and faxed to the Admissions Office (801-226-4641) 48 hours before your adolescent admits.**

_____ **Signature Pages (pp. 2 - 13)**

_____ **Interstate Compact Agreement (p. 14)**
Signature of parent/legal guardian is required in Section III where indicated by "Signature of Sending Agency or Person" and date signed. An Interstate Compact Placement for Children (ICPC) is required by Federal law for all children being placed outside their home state. It is used as a means to ensure that facilities are in compliance with the laws of both states involved, and enables a governing body to ensure that the placement is in the child's best interest.

_____ **OmniCare/Superior Care Pharmacy Form (p. 16 a, b)**
Everyone must fill this out and sign as "Financially Responsible Party Name" regardless of your prescription coverage.

_____ **Limited Durable Power of Attorney - LPOA (pp. 17 a, b, c, d)**
Heritage Schools, Inc. cannot allow any adolescent to admit without a filled out, signed, and notarized "Limited Durable Power of Attorney". A faxed copy must be in our office 48 hours before admit. The original must still be mailed. The LPOA does not give legal custody of your adolescent to Heritage Schools, Inc. It gives the School the right to act as the legal guardian of your child in your absence, gives us permission to seek emergency medical attention if needed, and allows us to involve local authorities in the search and return of the adolescent to Heritage in the event of an AWOL.

_____ **Admissions Agreement (pp. 18 a, b, c, d, e)**

_____ **$200.00 for Medication Account made payable to Superior Pharmacy**

_____ **A copy of Adolescent's Birth Certificate**

_____ **A copy of Adolescent's Current Immunization Record**
It is a Utah State law that all children attending school have current immunizations. We cannot legally enroll your adolescent in school until we have an immunization record. If you cannot locate your adolescent's immunization record, **he/she will be re-immunized within ten (10) days of admission at the parent's/legal guardian's expense.**

_____ **A copy of Adolescent's Medical, Dental, and Rx Cards (front and back)**

_____ **A copy of Adolescent's Social Security Card**

_____ **A copy of Adolescent's Complete Academic Transcripts**

_____ **Legal Custody Documentation (if applicable)**
This includes divorces, adoptions, state custody.

HERITAGE SCHOOLS INC.

Heritage Residential Treatment Center

g APPLICATION FOR ADMISSION g

****Submit Completed Application a Minimum of 48 Hours Prior to Admit****

Adolescent's Name:		Male ☐ Female ☐	Race:	
Date of Birth:	Age:	Birthplace:		
Religion:	Hair Color:	Eye Color:	Height:	Weight:
Adolescent's Soc Sec #:		Where Currently Living:		
Languages Spoken:		Where Previously Living:		
Person Providing Information:		Relationship to Adolescent:		

Emergency contacts other than persons in the same home adolescent is living:

Name:	Relationship:
Telephone #:	Other Phone:
Name:	Relationship:
Telephone #:	Other Phone:

Referred to Heritage by:

Educational Consultant: Yes ☐ No ☐ Name: _____ Phone: _____

Parent Advocate: Yes ☐ No ☐ Name: _____ Phone: _____

MEDICAL • DENTAL • PRESCRIPTION INSURANCE INFORMATION

- **Please include a copy of the front and back of your medical, dental, and prescription cards.**
- **If insurance claim forms are required, please enclose signed forms.**
- **If you do not have insurance or medicaid, you will be billed for all medical, dental and prescription charges for your adolescent.**
- **Parents / Guardians are required to put $200 into a medical account at Superior Care Pharmacy to cover medical costs and co-pays.**

Guarantor:		Guarantor's SS#:	
Guarantor's Employer:		Employer's Phone #:	
Employer's Address:			
Designated parent/guardian who will provide consent for adolescent's medical and dental services:			
PRIMARY	**Medical Insurance Provider:**	Member ID #:	
	Subscriber:	Group #:	
	Insurance Address:		Phone:
PRIMARY	**Prescription Provider:**	Member ID #:	
	Subscriber:	Group #:	
	Insurance Address:		Phone:
PRIMARY	**Dental Insurance Provider:**	Member ID #:	
	Subscriber:	Group #:	
	Insurance Address:		Phone:
SECONDARY	**Medical Insurance Provider:**	Member ID #:	
	Subscriber:	Group #:	
	Insurance Address:		Phone:

Adolescent's Name: _____

SECONDARY	**Prescription Provider:**	Member ID #:	
	Subscriber:	Group #:	
	Insurance Address:		Phone:
SECONDARY	**Dental Insurance Provider:**	Member ID #:	
	Subscriber:	Group #:	
	Insurance Address:		Phone:

FAMILY HISTORY

- **Please include a certified copy of legal custody documentation with this application if parents are divorced.**
- **If joint custody, both parents must be in agreement about this placement and sign the Admissions Agreement.**

Father's Name: _____ ☐ **Biological** ☐ **Adoptive**		**Home Address:** **Email Address:**	
Home Phone:	Work Phone:	Date of Birth:	SS #:
Cell Phone:	Other Phone:	Custody:	Receive Progress Reports: Yes ☐ No ☐
Occupation:	Highest Grade Completed:		Annual Income:
Mother's Name: _____ ☐ **Biological** ☐ **Adoptive**		**Home Address:** **Email Address:**	
Home Phone:	Work Phone:	Date of Birth:	SS #:
Cell Phone:	Other Phone:	Custody:	Receive Progress Reports: Yes ☐ No ☐
Occupation:	Highest Grade Completed:		Annual Income:
Other Parent Involved: _____ **Relationship:** ☐ **Step** ☐ **Other**		Address:	
Home Phone:	Work Phone:	Date of Birth:	SS #:
Cell Phone:	Other Phone:		Receive Progress Reports: Yes ~ No ~
Occupation:	Highest Grade Completed:		Annual Income:
Other Parent Involved: _____ **Relationship:** ☐ **Step** ☐ **Other**		Address:	
Home Phone:	Work Phone:	Date of Birth:	SS #:
Cell Phone:	Other Phone:		Receive Progress Reports: Yes ~ No ~
Occupation:	Highest Grade Completed:		Annual Income:

**** Use separate piece of paper if necessary to fill out the following sections****

Names of Family Members	Age	Relationship to Adolescent	Living with Adolescent
			☐ **Same Home** ☐ **Other**_____
			☐ **Same Home** ☐ **Other**_____
			☐ **Same Home** ☐ **Other**_____
			☐ **Same Home** ☐ **Other**_____
			☐ **Same Home** ☐ **Other**_____

Adolescent's Name: _____

Describe the pregnancy with this adolescent (i.e., normal, complications):

Describe the problems you would like your adolescent to work on at Heritage:

PERSONALITY - Describe the overall personality of your adolescent in the following three (3) phases of his / her life:

Birth to six years of age:

Please do not write in this space

Six to twelve years of age:

Please do not write in this space

Twelve years of age to present:

Please do not write in this space

Adolescent's Name: _____

FAMILY HISTORY
Describe the history of the relationship of your adolescent with his / her father:
Please do not write in this space
Describe the history of the relationship of your adolescent with his / her mother:
Please do not write in this space
Describe the history of the relationship of your adolescent with his / her stepfather:
Please do not write in this space
Describe the history of the relationship of your adolescent with his / her stepmother:
Please do not write in this space

Adolescent's Name: _____

Describe the history of the relationship of your adolescent with his / her siblings:

Please do not write in this space

Describe the history of the marriage and marriage relationship(s):
If there has been a divorce or separation, please describe. Include adolescent's reaction and age at the time of the divorce or separation.

Please do not write in this space

Family history of any chemical dependency, alcohol use, psychological or psychiatric problems:

Please do not write in this space

SOCIAL HISTORY - Describe the presenting problems your adolescent has in the following areas:

Family:

Please do not write in this space

Adolescent's Name: _____

Friends:
Please do not write in this space
School:
Please do not write in this space
Behavioral:
Please do not write in this space
Emotional:
Please do not write in this space

Adolescent's Name: _____

Describe your adolescent's overall strengths:

Please do not write in this space

ACADEMIC HISTORY - Describe your adolescent's school performance in the following three (3) phases (include grades, relationships, teachers, peers, classroom behavior):

Kindergarten to 6th grade:

Please do not write in this space

Junior High (7th , 8th , 9th):

Please do not write in this space

Adolescent's Name: _____

High School (10th , 11th , 12th):

Please do not write in this space

What do you perceive as your adolescent's current academic needs?

Most Recent School Attended:	**Current Grade:**
Address:	Phone #:

Attending Now? Yes ~ No ~	Grade Failures:
Suspensions? Yes ~ No ~	If yes, please explain:
Expulsions? Yes ~ No ~	If yes, please explain:

Level of Functioning: ☐ Above Average ☐ Average ☐ Below Average	Has your adolescent been academically assessed? Yes ☐ No ☐ Where / When:	On an IEP? Yes ~ No ~

School District Name:

Address: Phone:

Name and address of previous Jr. and Sr. high schools attended	**Grades**	**Years**	**Reason for Leaving**

Attended:				Adolescent's favorite class:
Pre-School	Yes ~	No ~		
Nursery School	Yes ~	No ~		Adolescent's least favorite class:
Kindergarten	Yes ~	No ~		
Special Ed.	Yes ~	No ~		Hobbies or interests:
Resource	Yes ~	No ~		

Adolescent's Name: _____

BEHAVIOR HISTORY

Characteristics of Adolescent - Rate the behaviors below using the following code:
0 = Not True 1 = Somewhat or Sometimes True 2 = Very True or Often True

	curses at others		physically aggressive toward others		noncompliant		suicidal / self injury
	challenges authority		quick temper / tantrums		impulsive		damages property
	poor hygiene		argues		uses substances		does not accept criticism
	seeks out negative peers		shows no remorse		secretive		stubborn
	avoids school		doesn't show empathy		climbs on roof		teases other children
	sad or unhappy		doesn't handle being told no by adults		overreacts		manipulative
	promiscuous		inserts objects into rectum or vagina		engages in sex play		exposes self to others
	sexual identity distress		sexually aggressive/molesting		lies		steals
	suicidal thoughts		pulls out own hair or eyelashes		strikes self		picks at skin or sores
	burns self		cuts self		bites self		bangs own head
	strikes peers		strikes adults		kicks others		bites others
	swallows non-food items						

Is there a history of running away: From home / foster home? Yes ☐ No ☐ How many times?_____
From residential care? Yes ☐ No ☐ How many times?_____

Type of runaway behavior - Check all that apply:

_____ stays on property but refuses to come back inside
_____ walks off but returns that same day
_____ stays out just one night but returns
_____ stays out many days

Comments: _____

_____

What things help the adolescent to regain control if he/she becomes agitated, violent, or loses control:

_____

_____

Has the adolescent ever experienced a safety hold: Yes ~ No ~
(A safety hold means to "physically hold" or "physically restrain" the adolescent if he/she is at risk for harming him/herself or others)

If Yes, when, where, how: _____

_____

About how often: _____ 1-2 times total over past year _____ once a month on average _____ once a week on average
_____ once a day on average _____ more than once a day

Describe substance abuse history (alcohol, tobacco, street drugs, when first tried, frequency and duration):

Treatment programs:

Describe any violence, bizarre activity, gang affiliation, or cult activity:

Describe any trauma your adolescent has experienced (physical or sexual abuse, rape, violence or witness thereof):

Adolescent's Name: ____

JUDICIAL HISTORY

Describe any juvenile judicial history (shoplifting, burglary, curfew, and court actions):			
Current Judicial Involvement (disposition, charges pending):		Probation Officer (name, address, phone, etc):	
Does the court have legal / temporary custody? Yes ~ No ~		Is the adolescent court ordered into treatment? Yes ~ No ~	
Community Service Hours:	Fines:	Other:	
PO Receive Reports? Yes ☐ No ☐	PO Receive 72-hour Call? Yes ☐ No ☐	PO Contact for Major Incidents / AWOLs? Yes ☐ No ☐	
Name of Court:			Phone:
Address:			

PSYCHIATRIC HISTORY

List ALL psychological/psychiatric services (counseling, out-patient therapy, acute in-patient hospitalizations. residential programs, etc.)

Provider's Name, Address, Telephone Number (List most recent first)	**Dates Seen**	**Problems Addressed**	**Services**
Name: Address: Phone:	From: To:		☐ outpatient ☐ psychiatrist ☐ hospitalization ☐ residential ☐ other
Name: Address: Phone:	From: To:		☐ outpatient ☐ psychiatrist ☐ hospitalization ☐ residential ☐ other
Name: Address: Phone:	From: To:		☐ outpatient ☐ psychiatrist ☐ hospitalization ☐ residential ☐ other
Name: Address: Phone:	From: To:		☐ outpatient ☐ psychiatrist ☐ hospitalization ☐ residential ☐ other
Name: Address: Phone:	From: To:		☐ outpatient ☐ psychiatrist ☐ hospitalization ☐ residential ☐ other
Name: Address: Phone:	From: To:		☐ outpatient ☐ psychiatrist ☐ hospitalization ☐ residential ☐ other

Adolescent's Name: _____

Describe your adolescent's level of success:

Placement History:

Has your adolescent ever resided in a foster home? Yes ~ No ~ How many? _____ When? _____

Has your adolescent been admitted to a psychiatric hospital? Yes ~ No ~ How many times? _____ When? _____

Additional Information: _____

Ever resided in another group home or residential care facility? Yes ~ No ~ How many times? _____ When? _____

Details/Why Discharged: _____

MEDICAL HISTORY

Describe general health of adolescent:

Are immunizations current? Yes ~ No ~ **A copy of immunizations is <u>required</u> to be submitted with this application**

If adolescent has been treated for any chronic illness, fractures, or surgeries, explain history of treatment:

Treating Doctor: Phone:

Medication History: (If more room is needed, write on back of this page)

Medication Name Last Dosage	Dates Taken Start	Dates Taken End	Why Prescribed?	Reason Ended	Results/ Side Effects

**** A supply of medications or prescriptions is <u>required</u> at the time of admission ****

Adolescent's Name: _____

Allergies:

Sleeping Problems:

Eating Problems:

Hallucinations:

Special Needs: Glasses / Contacts? Yes ~ No ~ Braces / Retainers? Yes ~ No ~ Hearing Aids? Yes ~ No ~

List any other medical problems or physical handicaps:

Has your adolescent ever had a serious illness or head injury or seizure? Yes ~ No ~ If yes, please explain:

Does your adolescent have any medical or dental conditions which would prevent him/her from participating in the daily academic routine, recreational activities, or physical education? Yes ~ No ~ If yes, please explain:

Has your adolescent attempted suicide or talked of it? Yes ~ No ~ If yes, please explain (how many times, when, how):

Sexually Active? Yes ☐ No ☐

If female, has your adolescent ever been pregnant or had an abortion? If yes, please explain:

Dental Exam: Date Last Seen: _____ Next Exam Due: _____ Work Needed: _____
Dentist: _____ Phone: _____
Address: _____

Orthodontia: Date Last Seen: _____ Next Exam Due: _____ Work Needed: _____
Orthodontist: _____ Phone: _____
Address: _____

Medical Exam: Date Last Seen: _____ Next Exam Due: _____ Work Needed: _____
Doctor: _____ Phone: _____
Address: _____

Last Hearing Evaluation:

Last Eye Exam:

Has your adolescent had any of the following? If yes, please include dates/ages:

	Yes	No	Date/Age		Yes	No	Date/Age
Asthma	~	~	_____	Heart Surgery	~	~	_____
Bed Wetting	~	~	_____	Kidney Disorders	~	~	_____
Bronchitis	~	~	_____	Migraines	~	~	_____
Chicken Pox	~	~	_____	Mumps	~	~	_____
Chronic Anemia	~	~	_____	Pneumonia	~	~	_____
Diabetes	~	~	_____	Polio	~	~	_____
Ear Infections	~	~	_____	Red Measles	~	~	_____
Epilepsy	~	~	_____	Rheumatic Fever	~	~	_____
Fractures	~	~	_____	Rheumatoid Arthritis	~	~	_____
Frequent Colds	~	~	_____	Scarlet Fever	~	~	_____
German Measles	~	~	_____	Seizures	~	~	_____
Hay Fever	~	~	_____	Thyroid Disease	~	~	_____
Head Injury	~	~	_____	Typhoid Fever	~	~	_____
Heart Condition	~	~	_____				

Has your adolescent ever received a tuberculin skin test? Yes 9 No 9 Date Last Tested: _____

Ever tested positive? Yes 9 No 9 If yes, what medication or treatment did he/she receive?

****Please include a copy of your adolescent's current immunization record with this application****
Utah state law requires proof of current immunizations, and if not provided, the adolescent will be re-immunized ten (10) days after admission.

HERITAGE SCHOOLS, INC.
g ADOLESCENT'S RIGHTS CONSENT g

Adolescent's Name: _____

Heritage Schools, Inc. shall support and protect the fundamental rights of each adolescent. Heritage believes that a lack of personal pride and self-worth is part of the problem disrupting the adolescent's life. We are committed to providing care that shows respect and fosters pride in regaining positive controls over one's own life. Every adolescent is acknowledged to have the following rights:

1. Whenever possible, the adolescent's family should assist in the determination that Heritage is the appropriate place to receive the care and treatment needed. As a part of that decision, the adolescent and family will be told of the type of care, treatment, discipline and control policy, and the rules and regulations of the program.
2. Every adolescent needs to maintain and strengthen relationships with their family and significant others in their life. To do so, they should have freedom to send and receive mail, make telephone calls to parents, and have approved visits. If telephone calls or visits are not considered helpful to the adolescent, they may be restricted by the primary therapist or treatment team. Reasons shall be given to the adolescent and assistance will be provided to resolve the difficulties leading to the restrictions. In-coming mail shall be opened in front of Heritage staff to check for contraband. Mail can only be restricted if a court order is in place or the treatment team deems it therapeutically necessary.
3. Every adolescent must learn to participate in decisions affecting his/her life. He/she should participate with the family and Heritage in exploring treatment alternatives and be involved in the planning for their care and treatment. To develop this skill, the adolescent and his/her family should be made aware of:
   a. The clinical staff responsible for the adolescent's care/treatment,
   b. Any changes in staff,
   c. The purpose and reasons for medication or other types of treatment,
   d. Any transfer of the adolescent to another phase of the program,
   e. Plans for treatment after discharge.
4. Heritage has a commitment to provide an appropriate program for each adolescent at Heritage. Trust of our care and treatment is necessary if we are going to succeed. The adolescent, along with his/her parent/guardian, has the right to question or refuse medication or treatment procedures and to request a review of the treatment plan. They also have the right to seek the opinion of an outside consultant (at personal expense). Should the adolescent's family feel they cannot accept the treatment plan, they may request the adolescent's removal from the program. Please refer to "The Early Withdrawal of Students" section in the Admissions Agreement for more details. Heritage will give assistance in finding another appropriate facility for the adolescent if:
   a. An agreement upon a treatment plan, appropriate to this setting, cannot be reached,
   b. After an appropriate period of treatment, Heritage is determined to no longer be the appropriate treatment program for the adolescent.
5. Adolescents occasionally are concerned about the cost of their care and the funding sources. Heritage views this as a family concern and will assist the adolescent and their family in answering such questions.
6. Adolescents and their families have a right to personal privacy. No audio/visual recordings, one-way mirrors, movies or photographs will be used without the adolescent and his/her family being advised as to its use and waiting for written permission.
7. Heritage does not do research or use experimental drugs.
8. One important part of our care and treatment is learning to resolve problems in a positive manner. Therefore, the adolescent and family are encouraged to present any questions, concerns, complaints, or grievances regarding the care and treatment being provided by Heritage Schools, Inc.. Such concerns are presented to the therapist or customer relations representative. Should the adolescent or family feel that the matter has not been satisfactorily resolved, they may contact the following:
   a. Clinical Director
   b. Board of Directors
9. The maintaining of confidential information in the adolescent's master file is very important. Records will <u>not</u> be disclosed to anyone not connected with our treatment program without written consent from the parent/legal guardian or a court order.
10. An adolescent can correspond with and have visits with religious clergy and his/her attorney in accordance with the rules of the treatment facility.
11. The clinical staff will assess the need for protective services for an adolescent. It is the duty of Heritage Clinical Staff to report to appropriate protective services suspected or real danger to any youth in our care.

I have read and understand the "Adolescent's Rights Consent" of Heritage Schools, Inc.

_____	_____	_____	_____
Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

HERITAGE SCHOOLS, INC.
g DISCIPLINE AND CONTROL CONSENT g

Adolescent's Name: _____

An essential part of the adolescent's care is keeping him/her from harming himself/herself or others and to maintain a healthy therapeutic environment, free from disruption. It is our basic belief that such controls must be seen as supportive and protective.

Acceptable Discipline:

1. Restriction of Privileges If an adolescent consistently has difficulty in following the program standards, the more desirable privileges in the program will be unavailable to him/her. This restriction is seen as supportive (i.e., "things will likely not go well for you with the activities because of the hard time you are having right now in living the rules"). When an adolescent is restricted from an activity, he/she remains behind with supervisory staff at Heritage. Other less desirable activities are provided as an alternative.
2. One-to-one (Staff Buddy) When an adolescent is at risk because of his/her behavior, the result is one adult and one adolescent close to or with each other at all times (i.e., "You are having a hard time; you need to be with me so I can help you"). One-to-one allows for close supervision and support.
3. One-to-one (Student Buddy) This method is used when it is thought that the support of a currently higher functioning peer would be in the best interest of the adolescent in order to succeed. It is also made clear that this student buddy is not to be part of any discipline or control of a peer. The student buddy's function is to support only.
4. Processing Off Unit and Away from Stimulus Many times an adolescent cannot be successful with problem solving in front of his/her peers or if there are distractions around. The use of an alternate, quiet area may many times lead to successful problem solving.
5. Writing Assignments In an effort to focus, slow down the thought process, and arrange thinking, adolescents will be asked to complete various writing assignments with certain objectives in mind.
6. Brief Stay on Another Unit This can offer an opportunity for an adolescent to start over and give the adolescent time and space to cool off.
7. Time-outs in Another Area The use of a time-out would not exceed 30 minutes. This is a cool-down period in a safe and quiet area that is supervised. It is after the "cool-down" period that processing by staff is attempted again.
8. Consolation Assisted by Resource Member This is available when either the adolescent or staff feels they are having problems interacting with each other and need a fresh perspective. There is a resource member available 24 hours a day.
9. Passive Physical Restraint or Holding Should an adolescent not be able to regain sufficient control to move to an area away from peers, or if his/her anxiety, fears, or anger are such that he/she requires assistance in regaining control, he/she may be physically restrained or held. The holding is not punitive. It is not meant to be harmful or hurtful, but rather a measure taken to prevent the client from presenting a danger to himself/herself or others.
10. Placement in the Intensive Support Unit The Intensive Support Unit (ISU) is used for observation and focused intervention. When an adolescent is experiencing a major disruptive cycle, is a high runaway risk, is considered at risk to himself/herself or others, or is a disruption to the therapeutic environment on the unit, he/she will be placed in ISU. Placement might also be considered if there is a specific treatment goal or objective that can best be met by focusing totally on that area of concern. Staff is available at all times while in ISU to help support the adolescent through his/her crisis. The length of stay in ISU is determined by the therapist who is required to see the adolescent daily.
11. Mute from Interaction with Others or a Specific Client This intervention might be used if the adolescent becomes verbally inappropriate with peers or a specific peer. This status would remain in effect until there is successful resolution of the presenting problem. This status does not limit the adolescent's interaction with the staff.
12. Unit Isolation An adolescent might be asked to stay on his/her own unit and limit his/her interactions to be only with staff. During this time the adolescent would complete writing assignments specific to the situation or limit the stimulus he/she would be asked to encounter. The adolescent would have alternatives for recreation such as reading, writing, drawing or playing cards alone.

Unacceptable Discipline:

A fundamental principle of Heritage is that discipline and control should not be punitive. The adolescent's destructive behaviors should be interrupted and redirected, but not by an attitude of retribution or by inflicting injury, pain, or other harm. Because of the above stated principle, the following disciplines are unacceptable:

1. Adolescent's may not be deprived of a meal.
2. An adolescent is not allowed to discipline another adolescent.
3. Circumstances may not be created for the purpose of causing ridicule or embarrassment to the adolescent.
4. Visits with family or relatives may not be restricted for disciplinary reasons. Visits may be restricted only when it is clinically indicated to be in the best interest of the adolescent or family.
5. Work may not be given to an adolescent as a punishment.
6. An adolescent may not be deprived of normal care (i.e., appropriate clothes, regular bathing, deprivation of sleep, etc.).
7. An adolescent may not be spanked, hit, or receive any other type of physical punishment of any manner upon his/her body.
8. The use of physical exercise, such as running laps or performing push-ups, will not be allowed as a means of punishment.
9. An adolescent may not be required to assume an uncomfortable position such as squatting or bending.
10. Group punishment for the misbehaving of an individual or individuals, unless clinically indicated in a specific circumstance, is prohibited.
11. An adolescent may not be subjected to verbal abuse.
12. Physical restraints are prohibited when used solely as a means of punishment.
13. The withholding of emotional response or stimulation for extended periods of time is prohibited.

If a parent or guardian feels that any disciplinary measure that has been used was cruel, unusual, inappropriate, or not in the best interest of his/her adolescent, the Executive Director should be notified immediately. Should the parent feel that the matter has not been satisfactorily resolved, the parent's concerns may be addressed in a written complaint to the Governing Board or the Professional Services Organization. It is the sincere wish of the staff at Heritage Schools, Inc. that the parent will bring all concerns regarding the treatment of his/her adolescent to the therapist's attention. It is only through trusting one another that we are able to do what is best for the adolescent.

I have read and understand the "Discipline and Control Consent" of Heritage Schools, Inc.

_____	_____	_____	_____
Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

HERITAGE SCHOOLS, INC.

✦ GENERAL AND EMERGENCY MEDICAL CARE CONSENT ✦

Adolescent's Name: _____

I authorize Heritage Schools' licensed medical staff to arrange for general medical, dental, and laboratory services **(all lab work will be billed to parents)** for my adolescent while enrolled at Heritage. It is my understanding that upon admission, a physical exam will be completed. This exam will include a pelvic exam and cultures for females who have been sexually active. A dental check-up will be given to the adolescent six months following the last dental exam; or if the adolescent is due for an exam, it will be completed shortly after admission. I understand that my private insurance will be billed for these procedures, and **I will be billed for the co-pays**. Heritage staff will contact the parent/guardian for approval prior to each off-campus medical or dental visit. It is my understanding that during the adolescent's stay at Heritage, a random urine drug screen will be conducted. This procedure may also occur following the adolescent's return to Heritage from a home visit.

If the judgement of a physician or other licensed medical staff indicates the need for emergency medical care, it is my understanding that every reasonable effort will be made to notify parent/guardian prior to any treatment and/or transfer of the adolescent to a medical facility. If, however, the emergency is life threatening and/or parent/guardian cannot be contacted by telephone, I authorize the transfer of the adolescent to a medical facility better able and equipped to render the medical/emergency care needed. I also authorize the release of pertinent medical records to the facility providing the medical/emergency care to the adolescent.

Immunizations: I understand and agree that my student will be immunized with the required vaccinations for the Utah School District within the Department of Health guidelines if the immunization record received at the time of admission does not indicate that the immunizations are current. **The student will be immunized within ten (10) days if there is no immunization record (or exemption) submitted. This will be done without notification and at my expense.** Utah law requires that all students must have two (2) documented doses of Measles, Mumps and Rubella vaccine, five (5) DTP/DTap/DT and three (3) OPV or four (4) IPV. Hepatitis B series, required for kindergarten entry after 7/01/03, is required for a student falling within such age category at the time of admission to this facility. **I also have to indicate at the time of admission, in the admission application, or in the immunization record if my child has had chicken pox**.

I have received and read the vaccine Information statements concerning Tet.-Diph., Polio, MMR and Heptatis B vaccines.

_____ _____ _____ _____

Parent/Guardian Signature Date Parent/Guardian Signature Date

✦ SEARCH AND SEIZURE CONSENT ✦

Personal Safety Search and Property Search Policy

The purpose of any search at Heritage Schools, Inc. is to ensure the safety of all adolescents and staff. An adolescent and/or their room and property may be searched at any time the treatment staff deems it therapeutically necessary for the well-being and safety of all. This is done to ensure that any prohibited, unlawful, stolen or hazardous items be confiscated by staff and returned to the owner or disposed of. Searches can be done only upon authorization and approval of the CEO (Chief Executive Officer) and/or the Safety Officer. It is the policy of Heritage Schools, Inc. to conduct a safety search on all adolescents at the time of admittance and on all adolescents returning to campus after visits. This search will be done by trained staff with the personal rights, privacy and dignity of the adolescent recognized at all times. The search will be conducted as follows:

Campus Supervisor or Safety Officer will be notified and the adolescent will be taken to a private room where two staff members will be present to conduct the safety search. The staff performing the search will be of the same gender as the adolescent. The adolescent will be asked to step behind a privacy screen, remove their clothing and hand it, a piece at a time, to the staff on the other side of the privacy screen. One of the staff will search each piece of clothing as it is handed to them. When all the clothing is removed, **one** staff member will position themselves so they are able to view the adolescent . The adolescent will be asked to turn around so that the body can be quickly observed to ensure there is no contraband hidden or attached to the body. AT NO TIME WILL THE ADOLESCENT BE TOUCHED BY THE STAFF IN ORDER TO BE SEARCHED. The observing staff member will then step away so that the adolescent is no longer being viewed, and the adolescent will then be given his/her clothing back and asked to dress. Please be assured that at all times the dignity of the adolescent will be considered most important.

I have read and understand the "Search and Seizure Consent" of Heritage Schools, Inc.

_____ _____ _____ _____

Parent/Guardian Signature Date Parent/Guardian Signature Date

HERITAGE SCHOOLS, INC.
g INSURANCE FAQ'S g

Adolescent's Name: _____

Q. Should I bring my insurance card with me to Heritage?
A. Yes, the information on your insurance card is needed for Heritage to file a claim with your insurance company or companies. When you register, we will ask for information about your insurance coverage and have you sign a few forms.

Q. How do I know if my insurance company will cover certain services?
A. Coverage varies with each insurance company. Generally, Heritage staff does not know whether a particular service will be covered. Medically necessary and appropriate services may not always be covered by your insurance contract. Please refer to your insurance member handbook or call your insurance company with questions.

Q. Do I need to let my insurance company know that my child will be at Heritage? What will they cover?
A. Your health insurance plan may have special requirements such as prior authorization or limitation on where care is provided. If your insurance plan's requirements are not followed, you may be financially responsible for all or part of the bill for services provided by Heritage. We encourage you to check with your insurance company or your employer about this. Because there are so many types of insurance plans, it is difficult for us to tell you whether or not you need prior approval or notification for your Heritage stay. Contact your insurance company or your employer with specific questions about what is or is not covered by your insurance plan.

Q. Will you bill my insurance company for me?
A. Yes, as a courtesy Heritage will submit bills to your insurance company when complete information is supplied. Please remember that your policy is a contract between you and your insurance company, and you have the final responsibility for payment of your bill. If your insurance company does not pay within 45 days of billing, please contact them to resolve the delay. Secondary insurance is billed after the primary (or first) insurance pays or denies.

Q. How do I follow up with my insurance company?
A. Before you call, have available your insurance card, date of service, facility name, original billed amount, patient name and claim number (if applicable). Obtain satisfactory status of account. If paid, ask when and to whom. Note this information and whom you talked with at the insurance company. If the bill has not been paid, find out when the anticipated payment date is and ask if they need anything from you. If the bill is not paid in the stated time frame, follow up with the insurance company again and, if necessary, request to speak with a supervisor.

Q. How will I know if my insurance company has paid my bill?
A. You should receive an Explanation of Benefits (E.O.B.) from your insurance company. If there is a balance due from you after the insurance company has paid its portion, we will send you a statement. This statement indicates the amount that has been paid and any balance you are required to pay. This is your bill. You are required to pay this bill in full or will need to contact our office.

Q. What do I do if I disagree with how much my insurance company has paid on my bill?
A. If you disagree with the insurance company's payment amount, contact the insurance company and ask them to review how the claim was processed. If the insurance company finds that an error was made, note the information and whom you talked with at the insurance company. Request an anticipated payment date and ask if they need anything from you. If the insurance company feels the bill was paid correctly and you still disagree, find out from the insurance company what you need to do to file an "appeal" with them. Filing an appeal will not guarantee that the insurance company will pay more on your bill, but the claim will be reviewed for reconsideration. You are ultimately responsible for payment regardless of what your insurance company may pay. Heritage accepts no liability for billing errors.

Heritage Schools, Inc., as a courtesy, will bill your insurance company or companies. You have the final responsibility for payment of your bill. Heritage does not guarantee payment by your insurance company and will not accept liability for any billing errors.

I have read and understand the above and agree to accept responsibility as outlined regarding my insurance coverages.

_____	_____	_____	_____
Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

HERITAGE SCHOOLS, INC.
g MEDICATION THERAPY CONSENT g

Adolescent's Name: _____

As a psychiatric treatment center, it is our philosophy, as sound clinical practice may dictate, that the use of medication therapy is a necessary and appropriate practice in treatment to achieve the highest clinical outcomes. As the client's capacity to function is enhanced and is clinically indicated, we may reduce and in some cases discontinue medication therapy. Medication monitoring is performed by trained medical, professional, and support staff.

The psychiatric staff in conjunction with the treatment team determines the need for medication. The psychiatric staff are the only ones who prescribe medications for psychiatric diagnosis. If medication is prescribed, the nurse will contact you regarding what medication is prescribed withall the necessary information you need for us to obtain your support.

If your child is on psychiatric medications, he/she will be seen by a member of the psychiatric staff once a month for medication monitoring. However, if you have questions or concerns about medications, you will need to speak with one of our nurses.

You have the right to disagree with the treatment plan which may include a psychiatric medication regime. However, if your decision hinders (in our opinion) the treatment progress of your child, then your case will be reviewed to determine appropriateness of placement in our facility.

1. Psychiatric medications may be prescribed for treatment. Do you have any issues or concerns? _____

_____

_____

_____

2. Have you ever withheld your approval for psychiatric medications for your child? _____ If so, why? _____

_____

_____

3. Herbal remedies are not administered here. Do you have a concern? _____ Explain _____

_____

_____

4. Has your child had any negative side effects from psychiatric medications? _____ If so, explain _____

_____

_____

5. What medications do you feel have worked or not worked? _____

_____

_____

_____

6. Who would you like to be designated as the contact/approval parent for medications? _____

_____

I have read and completed the "Medication Therapy Consent" of Heritage Schools, Inc.

_____ _____ _____ _____

Parent/Guardian Signature Date Parent/Guardian Signature Date

HERITAGE SCHOOLS, INC.

g PARENT'S RIGHTS RESPONSIBILITIES AND ETHICS CONSENT g

Adolescent's Name: _____

1. You have the right to be informed about your child's care and treatment including:
   a. Professional staff responsible for your child's care
   b. Risks, side effects, and benefits of all medications and treatment procedures
   c. Use of observation and audio-visual techniques
   d. Cost of services provided
2. You have the right to request the opinion of a consultant, at your expense.
3. You have the right to privacy of communications between clients and staff, and of information in all records.
4. You have the right to refuse participation in any research project without affecting treatment services.
5. You have the right to know plans for discharge of your adolescent.
6. You have the right to know the rules about behavior on the Unit.
7. You have the right to know that although appropriate staff-to-client ratios are always maintained, this does not always stop a client from experiencing injuries.
8. You have the right to know that once a client demonstrates responsible behavior, he/she will have earned the privilege to participate in therapeutic activities off the campus.
9. You have the right to visit your adolescent according to the rules of the Center.
10. You have the right for your adolescent to receive visits from your clergy or attorney at any reasonable time.
11. You have the right to send mail to and receive mail from your adolescent.
12. You have the right to conduct private telephone conversations with your adolescent.
13. You have the right to know that if restrictions are necessary, they will be reviewed regularly by the treatment team.
14. You have the right to know that Heritage Schools, Inc. is not liable for lost or stolen articles.
15. You have the right to know that your adolescent and/or his/her possessions may be searched if clinically justified.
16. You have the right to present questions, concerns, complaints, or grievances regarding the care and treatment being provided by Heritage Schools, Inc. Such concerns may be provided to the primary therapist or other members of the treatment team. A formal grievance form can be requested from the Parent Liaison or other personnel.
17. You have the right and responsibility to review and sign various special education documents if your adolescent is being funded by a school district or if he/she is on an Individual Education Program (IEP).

I have read and understand the "Parents Rights, Responsibilities and Ethics Consent" of Heritage Schools, Inc.

_____	_____	_____	_____
Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

g MENTORING PROGRAM CONSENT g

At Heritage Schools, your son/daughter, if he/she desires, will have the opportunity to participate in our Mentoring Program. This program will enable your son/daughter to meet with a mentor once a week for thirty (30) to sixty (60) minutes. The mentor is assigned by the Volunteer Coordinator and will be the same gender as the client. The Mentoring Program is non-religious and is designed to instill hope, trust, and freedom from fear, providing a new outlook with purpose in life. Emphasis is placed on reconnecting with family, community, and school.

The Mentoring Program is a voluntary program for which we need your written consent in order for your son/daughter to participate.

I have read and understand the "Mentoring Program Consent" of Heritage Schools, Inc. My adolescent has permission to participate in the program.

Yes ~ **No** ~

_____	_____	_____	_____
Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

HERITAGE SCHOOLS, INC.

g PARENT'S RIGHTS FOR SPECIAL EDUCATION CONSENT (PL 94-142) g

Adolescent's Name: _____

Current federal legislation requires that school districts provide an explanation of the procedural safeguards available to parents whenever a district proposes to initiate or change the identification, evaluation, or educational placement of a child. A summary of the rights included in this legislation is listed below. More detailed information is available upon request. Please read, sign, and return this statement as soon as possible for our records.

EVALUATION: Parents have the right to refer their child (birth to age 21) for an educational evaluation.
Parents have the right to receive prior written notice before the school district proposes or refuses to initiate or change the identification, evaluation or educational placement of their child. This written notice shall be provided in the native language of the parent or other mode of communication used by the parent. If the native language is not a written language, the notice shall be translated orally or by other means to the parent in their native language or other mode of communication. Parents must provide informed written consent prior to the district initiating an educational evaluation. Whenever an assessment is to be conducted, the parent shall be given, in writing, a proposed assessment plan within fifteen (15) calendar days of that referral for assessment. Upon receipt of written parent consent, a full and individual evaluation of the child's educational needs shall be complete within fifty (50) calendar days, not counting days between regular school sessions or days of school vacation in excess of five school days or school/calendar days of that referral for assessment.

Parents have the right to review all assessment procedures and instructions, to be fully informed of assessment results, and to obtain upon request a copy of the findings of the assessment conducted. The district will ensure that testing does not discriminate on the basis of language or culture, that tests are validated for the specific purposes for which they are used, that tests are sensitive to impaired sensory, manual or speaking skills, that assessments will be conducted in all areas of suspected disability, and that no single test instrument or procedure will be used in determining an appropriate education program. Evaluations will be conducted by a multi-disciplinary team qualified in the areas of educational assessment.

Parents have the right to obtain an independent educational assessment which must be considered by the school district in any decision regarding their child if the parents disagree with an assessment obtained by the district personnel.

The Special Education Local Plan Area (SELPA) shall ensure that the interpretation of the evaluation data and subsequent determination educational needs shall be made by a team knowledgeable about the child. The parent has the right to participate in a meeting devoted to recommendations and program planning for his/her child. No child may be placed in a special education program without a full and individual preplacement evaluation.

Parents have the right to participate in all planning meetings regarding the educational needs of their child and to present information to the school in person or through a representative. These meetings should be scheduled at mutually convenient times to facilitate parental attendance.

Parents and the District/SELPA have the right to make an audiotape recording of the Individualized Education Program (IEP) Team meeting by giving 24- hours notice to the IEP Team of the intent to tape the meeting. If the District/SELPA gives notice of intent to audiotape the meeting and the parent objects or refuses to attend, then the meeting shall not be tape recorded.

SPECIAL EDUCATION AND RELATED SERVICES: Each child diagnosed as a pupil with exceptional needs has the right to be educated with non-disabled children to the maximum extent appropriate. Placement in special classes occurs only when the child's disability is such that education in a regular class, with the use of supplementary aids and services, does not adequately meet the needs of the child. Nonpublic school services will be provided when no appropriate public school program is available.

Parents must provide informed written consent prior to their child's participation in any special education program. Parents have the right to revoke the consent at any time after consulting with a member of the IEP Team and after submission of written notification to the Administrator. The IEP shall be developed within thirty (30) days after the start of the new regular school year if the referral was made twenty (20) days or less prior to the end of the regular school year. For school vacations, the fifty (50) day time starts again when school reconvenes. Parents have the right to a copy of their child's IEP. A copy of the IEP shall be provided in the primary language upon request. Parents may request a meeting with school personnel to develop, review, or revise the IEP. Student progress shall be reviewed at least annually. Parents have the right to request a formal reassessment of their child at any time, even though a complete formal reassessment will be conducted every three (3) years.

CONFIDENTIALITY OF INFORMATION: All records pertaining to identification, evaluation, or placement of a child will be maintained at the appropriate district site and on file at the child's school of attendance. Parents have the right to inspect, review, and be provided copies of records. Parents also maintain the right to receive a list of types and location of records being collected and may receive an explanation of any item in the records. Parents can be charged for the cost of duplication of materials.

Parents have the right to request an amendment to any records on the basis of inaccuracy or as a violation of privacy and may restrict access to all records by withholding consent to disclose records to any one except qualified school personnel.

APPEAL AND HEARING PROCEDURES: Parents have the right to request of the State Department of Education an impartial due-process hearing to question the district's identification, evaluation, and/or placement of their child and to request a complaint investigation to question the district's compliance with the law. The parent has the right to information regarding free or low cost legal services.

Upon receipt of the parent's written request for a due process hearing, the Superintendent of Public Instruction shall immediately notify both parties of a proposed date for a mediation conference. This conference shall be conducted prior to the due process hearing, unless either party waves the conference, and shall be completed within fifteen (15) calendar days of receipt of the request. The student remains in the current placement during the hearing and judicial process.

The parent has the right to a mediation conference, to examine pupil records, to meet with the pupil at the hearing, and to open the State hearing to the public. If the mediation conference fails to resolve the issues to the satisfaction of both parties, a State-level hearing shall be held.
A parent/guardian who prevails in either a hearing or court action may recover reasonable attorney's fees using the appropriate judicial procedures.

I have read and understand the "Parent's Rights for Special Education Consent (PL 94-142)".

_____	_____	_____	_____
Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

HERITAGE SCHOOLS, INC.

g PERMISSION TO EVALUATE CONSENT g

Adolescent's Name: _____

In order to develop the best educational program for every student, it is sometimes necessary to obtain additional information concerning the adolescent's skills. We would like to have your permission, as parent/legal guardian, to have our professional staff at Heritage evaluate your adolescent in the following areas. The type and purpose of evaluations Heritage Schools, Inc. uses are listed below. Not all these tests will be administered to your adolescent–only those appropriate to gather the necessary information. If you have any concerns about any of the proposed testing, please contact Heritage Schools, Inc. Academics Department at 1-801-226-4600, ext. 221.

INTELLECTUAL - *To measure current strengths and weaknesses in mental abilities.*
Wechsler Intelligence Scales for Children, Revised, III
Woodcock Johnson Psycho-Educational Battery
Woodcock Johnson Psycho-Educational Battery, Revised
Wechsler Adult Intelligence Scale - Revised - III (WAIS-III)
Wechsler Intelligence Scale for Children - Revised - IV (WISC-IV)
Wechsler Memory Scale-Revised (to assess memory skills)
Ravens Colored Progressive Matrices
Trails A & B Tests
Other _____

EDUCATIONAL - *To estimate level of educational functioning in basic skills.*

Woodcock-Johnson Psycho-Educational Battery
Woodcock-Johnson Psycho-Educational Battery, Revised
Key Math
Key Math, Revised
Test of Written Language
Woodcock Reading Mastery Tests
Other _____

Wide Range Achievement Test (WRAT 3)
WIAT
Detroit
Criterion Referenced Testing
The Learning Disability Evaluation Scale
Peabody Individual Achievement Test

SOCIAL/EMOTIONAL/ADAPTIVE - *To determine independence and social functioning in school/home/community.*

Rorschach Test
Draw-A-Person, Family
Burk's Behavior Rating Scales
Sentence Completion
The Attention Deficit Disorders Evaluation Scale
Child Behavior Checklist (Achenbach)
Childhood Behavioral Patterns
Teenage Behavioral Patterns
Current Behavioral Patterns
Other _____

Thematic Apperception Test (TAT
Teacher's Report Form (Achenbach)
Conner's Teacher/Parent Rating Scale
Classroom Observation
Pier-Harris Self-Concept Scale
Symptom Checklist 90-Revised
Carlisle Fantasy Analysis System (C-FAS)
NIDA Drug & Alcohol Abuse Intake INterview

VISUAL - *To assess whether or not the student has a visual handicap of such degree that it prevents success in the regular classroom, as well as assess the student's eye/hand coordination on paper pencil tasks.*

Frostig Development of Test of Visual Perception
Dvorine Color Plates
Snellen Eye Chart
Hooper Visual Organization Test
Other _____

Visual Motor Developmental Screening
Visual Motor Integration Test
Benton Visual Retention Test

AUDIOMETRIC/SPEECH/LANGUAGE - *To assess the abilities needed in hearing, understanding, and producing language.*

Woodcock-Johnson Psycho-Educational Battery
Woodcock-Johnson Psycho-Educational Battery, Revised
Audiometric Testing (Pure Tone Testing and/or Bone Conduction Testing)
Illinois test of Psycho linguistic Abilities
Detroit Test of Learning Aptitude
Test of Adolescent Language
Test of Written Spelling
Expressive One Word Vocabulary Test
Lindamood Auditory Concepts Test
Wepman-Morency Auditory Tests
Structured Photographic Language Test
Flowers-Costello Test of Auditory Abilities
Goldman-Fristoe Test of Articulation
Arizona Test of Fluency
PPVT (Peabody Picture Vocabulary Test)
Test of Language Development
Test of Written Language
Carrow Elicited Language Inventory
Other _____

PSYCHO-MOTOR - *These tests measure development prerequisites to academic skills.*

Woodcock-Johnson Psycho-Educational Battery, Revised
Woodcock-Johnson Psycho-Educational Battery
Other _____
Bender Visual Motor Gestalt
Classroom Observation
Developmental Test of Visual Motor Integration

NEUROPSYCHOLOGICAL - *These tests assess possible neurological problems.*

Halstead Reitan Battery
Weschler Memory Scale-Revised
Warrington Recognition Memory Test
Tinker Toy Test
Other _____
Wisconsin Card Sorting Test
Rey Auditory Verbal Learning Test
Rey Osterreith Complex Figure Design
Word Fluency

When this evaluation package assessment is completed, a conference call will be arranged with you to review and discuss the results. The evaluation will be kept confidential and the results will not be released without your permission. You are welcome to review your student's school records, including the results of this evaluation. Your student's placement in school will not be changed as a result of this evaluation without your approval.

This evaluation can only be done upon receipt of your written permission. If you would like to obtain an independent evaluation, you may do so, at your expense. Heritage school personnel can help you find a resource to obtain this evaluation if you do not know where and how to obtain it.

PLEASE SIGN ONE OF THE FOLLOWING:

~ **YES.** I authorize the evaluation requested for my adolescent: _____

whose date of birth is _____.

_____ _____ _____ _____
Parent/Guardian Signature Date Parent/Guardian Signature Date

I have been informed of my rights as a parent/guardian under provision "Parent's Rights for Special Education" (PL 94-142, p. 8 of this packet).

~ **NO.** I do not authorize the evaluation requested for my adolescent: _____

whose date of birth is _____.

_____ _____ _____ _____
Parent/Guardian Signature Date Parent/Guardian Signature Date

I have been informed of my rights as a parent/guardian under provision "Parent's Rights for Special Education" (PL 94-142, p. 8 of this packet).

HERITAGE SCHOOLS, INC.
✦ PROGRAM PHILOSOPHY CONSENT ✦

Adolescent's Name: _____

Heritage Schools, Inc. is committed to providing adolescents with opportunities and experiences that will assist them in discovering patterns that limit their growth. The programs are designed to facilitate adolescents in going beyond their regular boundaries and shifting to life experiences that are full of possibility and choice. Many young people live their lives in the context of survival, just getting by, coping and accommodating, breaking normal attachments, and resisting change. Survival is an attitude that produces fear and pain, conflict and distance. It means repeating what is familiar even if it limits one's growth and satisfaction. Heritage is committed to helping adolescents go beyond reaction and survival to experiencing choice and responsibility, where young people can feel they are a source of change and empowerment in their own lives.

PHILOSOPHY OF TREATMENT

Heritage Schools, Inc. approaches the treatment of its adolescents from the point of view that the most crucial issue is one of healthy relationships. As a starting place for understanding our program, we will begin with a basic discussion of normal relationship development and the treatment program we have developed to address the problem.

Normal Relationship Development

A newborn infant is totally dependent on others for its survival. Each time infants have a need, they become uncomfortable and express this by crying and increased motor movements. With each need filling response from a care giver, the child builds an increasing trust of care.

In addition to meeting the child's physical needs, care givers also provide a great deal of nurture or social interaction such as touch, speech, eye contact, and rocking. These nurturing behaviors are as crucial as meeting the child's physical needs, and without them children can be emotionally, physically, and intellectually delayed or even fail to survive.

As children grow and develop, they have an ever increasing mobility that allows them to interact independently within their environment. Dangers to the child, as well as social expectations, require a limiting and redirecting of the child's actions. The child's first response to such restrictions is a rage (the classical two-year-old tantrum). Gradually the child recognizes the benefit to both self and others when cooperating. A healthy independence develops, and the child begins making choices within responsible limits set by others. The child has a trust of control by others.

The primary disciplinary tool that is used during the child's growing independence is variations in nurture. When we are pleased, we smile, praise, caress, and cuddle the child. When we are displeased, we use negative variations of nurture such as a frown and a rough voice. As children grow older, they begin to have the values of the care giver within themselves. They are now telling themselves, "yes" or "no". In addition, the child has internal feelings in response to doing right and wrong. Doing good feels good; doing bad feels bad. The child has the beginnings of a conscience, a trust of self.

These three levels of trust: trust of care, trust of control, and trust of self are the basic elements of emotional attachment. The child has a life-long bond to other human beings. This bond becomes the basic building block of human relationships and is essential to friendship, marriage, parenting, work relationships and a meaningful, moral participation in society.

Healthy Relationship Disruptions

There are many things that can occur in a child's life that may disrupt the development of a normal relationship. The following list summarizes some, but not all, of the possibilities.

Pre-birth and Birth Factors: The child enters the world with conditions preventing him/her from experiencing care giving in a manner which promotes healthy attachment. Some children are born with sensory of stimulation difficulties which result in normal care being unpleasant or even painful to the child. Thus, the child recoils from care.

Learning and Perception Disabilities: Because of learning and perception disabilities, some children do not experience or understand the world like most children. The anxiety and confusion about this world, and more importantly, their misperception of care given to them, can result in a failure to develop the crucial levels of trust.

Physical Limitations and Handicaps: Physical limitations and handicaps can cause a child to experience care in a distorted manner. For example, these children need alternative kinds of care to compensate for part of the caring experience that is lost through their handicap. Many times months go by before the limitation or handicap is discovered or when it is discovered, there is limited understanding of the kinds of compensatory care necessary to facilitate a normal emotional connection.

Parent Factors: Before discussing parenting, it is important to note that there are many circumstances in the life of a child over which no family has control. Furthermore, none of us came fully prepared for the task of parenting, and blaming is not helpful. Anxious, uncomfortable care givers cause the child to experience a world that appears unsafe and harder to trust. Parents who came to the task unprepared or who are under many other forms of stress, can be very anxious in their attempts to do what is best for the child. Care by parents who are attempting to structure carefully what they do for their child can be overly rigid. If care is more by schedule than by the interactions of demand and response, the child has greater difficulty trusting that his/her needs will be met by the care giver. Unpredictable care means that the child does not experience a consistency that allows him/her to develop a high level of trust that his/her needs will be met. Family crisis or illness, such as a series of moves or frequent changes in baby sitters, can disrupt a consistent pattern of care and the type of care received.

Trauma: A harmful incident or series of incidents can occur in the life of a child. Illness or accidents which are experienced by the child as painful and through which he perceives the parents as failing to protect him (no matter what the parents may have done) can result in the child's losing trust. For a child, a hospitalization can feel like abandonment. Family problems can disrupt a comfortable parent-child relationship. Frequent moves, unemployment, financial hardships, illness, death of a family member, or divorce can dramatically change the previously healthy self-worth and attachment patterns. Often parents are unaware of what the child is experiencing, or they do not know how to help the child through the experience.

Other Factors: Occurrences outside the home, such as those with peers and community, can also disrupt relationship development. For some children, entry into school can be a trauma that affects trust. For example, the child's learning disability suddenly becomes obvious and puts him/her in a position of being unable to compete or hold his/her own.

Adolescent's Name: _____

The Emotionally Distant Adolescent

When a young person fails to develop an attachment, a number of characteristics emerge. All or some of these characteristics can be present in varying degrees or intensity, depending on the severity of the circumstances that led to disruption of the attachment. Depending on the adolescent's personality, these characteristics can also be decreased or intensified by the response of the family and others to the adolescent who is distant.

Fear/Rage Reaction: When an adolescent perceives in his mind that his/her needs will not be met, his/her response is one of fear, an intense fear that he/she will not survive. Blended into fear is also a rage response to the feelings that a trust has been betrayed. Both the fear and the rage are primitive or infantile in their intensity. The adolescent may cover over the fear and rage, feeling that if the feelings were acted out, he/she would either be harmed or harm others. These feelings then become viewed as another potential threat to survive. At other times, the fear and rage may be acted out in temper-tantrum-type episodes.

Loss of Trust: Having assumed that others will not meet his/her needs, the adolescent takes responsibility for himself /herself and in essence becomes self-parenting. To protect himself, a resistance to closeness and control develops. The adolescent uses manipulation of others and the environment in an attempt to meet his/her own needs.

Reversal of Learning: The adolescent's resistance to closeness means the nurturing responses that we use to shape children's behavior lose their value with this adolescent. We cannot depend on the meaningfulness of our relationship to pull the young person toward desirable behavior. In fact, the opposite occurs. Behaviors which drive people away or lessen their demands are reinforced while behaviors that draw others close are decreased. This reversal in learning leads to a learned pathology. Parents, unaware of the self-worth and attachment difficulties, are parenting their child much like other parents, while neighbors, relatives, and even professionals are encouraging setting limits and giving attention. When this does not work, they are judged by others (or even judge themselves) as being at fault. They begin to feel guilty, and guilt is a very powerful, manipulative tool in the hands of this adolescent.

Sadness: While frightened and evading closeness, the adolescent continues to have the basic human need for closeness. The adolescent presents an approach to, then avoidance of, closeness that confuses and frustrates care givers. The inability to find a way to meet this need leaves the adolescent feeling a deep sadness, a loss of a sense of self-worth, that he is not worthwhile enough to be cared for or deserving of affection. Often these adolescents present other feelings, either to cover over the sadness or to act out their fury over the emptiness that they feel. Those feelings also confuse and push others away, intensifying the sense of being alone.

Feeling Confusion: Believing that his needs will not be met, the adolescent tries to block out needs and feelings. In addition, he tries to cover over the sadness, the fear, and the rage. Failing to contain them, sporadic outbursts of feelings occur that are inappropriate to the circumstances. The adolescent may present anger, when in fact he is feeling sadness or fear. He may have a generalized anxiety or appear to have no feelings at all. The unusual blending of feelings puts parents in the position of guessing what the adolescent needs or wants and limits their ability to respond appropriately to the adolescent. This further reinforces the adolescent's perception that care givers will not meet his needs.

Symptoms of the Distant Adolescent

Looking beyond general characteristics of the emotionally distant adolescent, we can also identify, more specifically, symptoms or behaviors that are indicators of a lack of attachment and low self-esteem. Among these are:

Poor Eye contact: Having failed in the early relationship development processes, the adolescent does not relate on a face-to-face basis. Eye contact is a key ingredient of close human relationships. Poor eye contact reflects discomfort with trust and closeness.

Lack of Conscience Development: Having failed to develop closeness, the adolescent also fails to identify with the values of the family. In addition to a poor sense of right and wrong, or none, the adolescent also has little emotional response around right and wrong issues. There is limited guilt around doing "bad" things, but also little joy from doing "good" things.

Behaviors That Distance Others: A number of different behaviors are learned that effectively keep others distant or function to manipulate others. Among these are:

Withdrawal: This adolescent is always somewhere else when there are social interactions. He withdraws either physically or emotionally. The emotional withdrawal can be represented by the adolescent who is depressed or the adolescent who creates a world away of daydream and fantasy.
Aggression: No one likes to be hurt physically or emotionally. Aggressive behavior is a powerful means of either keeping others distant or giving in, in order to "keep the peace".
Promiscuous Behavior: This adolescent "loves" everybody, but an adolescent who loves everybody loves no one. The issue is an affection that is to such an extreme that it causes discomfort and actually pushes people away. The affection can be so indiscriminate that it appears that the adolescent has no "special relationships". Special relationships are what make attachments and parent-child relationships of value.
Over-Competence: The more one can do for himself, the less he needs to depend on others. The adolescent who is managing his own care is also avoiding needing or interacting with others.
Bizarre Behavior: Most people are frightened or at least avoidant of behavior that is bizarre and different. Threats of suicide can push people away, as well as greatly decrease their expectations and demands on an adolescent.
Substance Abuse: Alcohol and drugs alter the mind of a young person while allowing him/her to escape pain and closeness. Though this is an artificial way of trying to "feel good", it successfully works at keeping others at a distance.
Defiance: Defiance keeps others at bay by escalating power struggles and instigating incidents. Care givers who try desperately over and over to win cooperation, often burn out in the process.
Association With "Undesirable Friends": Peers that are supportive of weakening behaviors only add to the care giver's frustration and feelings of helplessness.

I have read and understand the "Program Philosophy Consent" of Heritage Schools, Inc.

_____	_____	_____	_____
Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

HERITAGE SCHOOLS, INC.
g SAFETY HOLD CONSENT g

Adolescent's Name: _____

Should an adolescent not be able to regain sufficient control to move to an area away from peers, or if his/her anxiety, fears, or anger are such that he/she requires assistance in regaining control, he/she may be physically held. The holding is not punitive. It is not meant to be harmful or hurtful, but rather a measure taken to prevent the adolescent from presenting a danger to himself/herself or others. Should holding become necessary, it is done according to the Crisis Prevention Institute regulations, and every effort is made to inflict no pain. It would be helpful to know the following information about your adolescent:

Has the adolescent ever experienced a safety hold: **Yes** ~ **No** ~

If Yes, when: _____

_____

About how often: _____ 1-2 times total over past year _____ once per month on average _____ once per week on average

_____ once per day on average _____ more than once per day

According to the adolescent, what things help the adolescent to regain control if he/she becomes extremely agitated, violent, or loses control:

_____

_____

According to the parent/legal guardian, what things help the adolescent regain control if he/she becomes extremely agitated, violent, or loses control:

_____

_____

Does the adolescent have any psychological, medical conditions, or physical disabilities that would place the adolescent at greater risk during safety holds:

- ~ History of sexual abuse
- ~ History of physical abuse
- ~ Hypertension
- ~ History of MI or cardiac disease
- ~ History of CVA
- ~ Presently detoxifying from drugs or alcohol
- ~ Presently pregnant
- ~ Arthritis
- ~ Osteomyelitis
- ~ Other bone or joint disease: _____
- ~ Any type of existing bone fracture
- ~ Physical disability: _____
- ~ Paralysis: _____
- ~ Other: _____

I have read, understand, and agree to the "Safety Hold Consent" of Heritage Schools, Inc. I understand that non-physical techniques in the management of behavior are the preferred intervention.

_____ _____ _____ _____

Parent/Guardian Signature Date Parent/Guardian Signature Date

g SECLUSION CONSENT g

In the event an adolescent reaches a level of agitation and/or out of control behavior that he/she is at risk for presenting a danger to himself/herself or others, the adolescent may be placed in a seclusion area. The adolescent is monitored by staff at all times.

I have read, understand, and agree to the "Seclusion Consent" of Heritage Schools, Inc. I understand that non-physical techniques in the management of behavior are the preferred intervention.

_____ _____ _____ _____

Parent/Guardian Signature Date Parent/Guardian Signature Date

HERITAGE SCHOOLS, INC.

g TELEPHONE CALLS, VISITATION, MAIL RESTRICTION CONSENT g

Adolescent's Name: _____

- If parents are divorced or legally separated with joint custody, mail, telephone calls, and visits for the adolescent cannot be restricted for either parent unless documentation of a court-ordered restraining order is on file with the Heritage Schools, Inc.
- The parents/guardians may have one 20-minute phone call per week with their adolescent. Telephone calls made by the adolescent to parents/guardians must be on a collect-call basis, or a calling card may be used. The calling card must be provided by the parent/guardian.
- We do not allow adolescents to make phone calls to extended family members or friends unless the adolescent's therapist approves those calls.
- Each adolescent is assigned an identification (I.D.) number upon admission which will be given to the parent/guardian. When calling Heritage Schools, Inc., this number must be given to the receptionist in order to access your adolescent. The I.D. number should not be given to anyone without consulting your adolescent's therapist or customer relations representative. It should never be given to the adolescent.
- All visits to the adolescent must be pre-approved with the parents, primary therapist, and the treatment team; and all visitors must check in with the Heritage receptionist at the time of the visit.
- I acknowledge that there are inherent risks involved in any home visits for my adolescent including, but not limited to, the potential of a run, accident, inappropriate sexual behavior, self-harm, harm to others, etc. In acknowledging these risks, I also accept full responsibility and liability for my child while he/she is in my care and release Heritage Schools, Inc. from all liability during the visit.
- Heritage Schools, Inc. may restrict an adolescent's telephone calls, visits, incoming and/or outgoing mail at the request of the parent/guardian. Both parents must approve any restrictions.

My Adolescent May <u>NOT</u> Have Any Contact with the Following Individuals:

NAME AND ADDRESS	RELATIONSHIP

_____ _____ _____ _____

Parent/Guardian Signature Date Parent/Guardian Signature Date

HERITAGE SCHOOLS, INC.
g E- MAIL CONSENT g

Adolescent's Name: _____

Heritage Schools, Inc., dba Heritage Residential Treatment Center, provides parents/guardians the opportunity to communicate with Heritage staff by e-mail. It is the policy of Heritage Schools, Inc. that Heritage will make all e-mail messages, sent or received, that concern the diagnosis or treatment of a client part of that client's medical record and will treat such e-mail messages with the same degree of security and confidentiality as afforded other portions of the medical record. Because of the risks outlined below, Heritage cannot, however, guarantee the security and confidentiality of e-mail communication. Clients and parents/guardians must consent to the use of e-mail for confidential medical information after having been informed of the following risks.

Consent to the Use of E-mail Includes Agreement with the Following Conditions:

- I/We acknowledge that e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- I/We acknowledge that recipients can forward e-mail messages to other recipients without the original sender's permission or knowledge.
- I/We acknowledge that e-mail users can easily mis-address an e-mail.
- I/We acknowledge that e-mail is easier to falsify than handwritten or signed documents.
- I/We acknowledge that backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
- I/We acknowledge that e-mail containing information pertaining to a client's diagnosis and/or treatment must be included in the client's Heritage medical record, thus all individuals who have access to the Heritage medical record will have access to the e-mail message.
- I/We acknowledge that employers most often do not give their employees a "right to privacy" in their e-mail system, so parents/guardians may choose *not* to use their employers e-mail system to transmit or receive confidential information.
- I/We acknowledge that if employers or others, such as insurance companies, read an employee's e-mail and learn of medical treatment, particularly mental health, sexually transmitted diseases, or alcohol and drug abuse information, they may discriminate against the employee. For example, they may fire the employee, not promote the employee, deny insurance coverage, etc. In addition, the employee could suffer social stigma from the disclosure of such information.
- I/We acknowledge that parents/guardians have no way of anticipating how soon Heritage and its employees will respond to e-mail messages. Although Heritage and its employees will endeavor to read and respond to e-mail messages promptly. Heritage cannot guarantee that e-mail will be read and responded to within any particular time period. If a parent's/guardian's e-mail invites a response and the recipient does not respond within a reasonable time, the parent/guardian is responsible for following up to determine whether the intended recipient received the e-mail and when the recipient will respond. Parents/ guardians should not use e-mail in a medical emergency.
- I/We acknowledge that Heritage may forward e-mail messages within the facility as necessary for treatment purposes. Heritage will not, however, forward the e-mail outside the facility without the consent of the client/parent or as required by law.
- I/We acknowledge that if the parent/guardian consents to the use of e-mail, he/she is responsible to inform Heritage of any types of information they do not want to be sent via e-mail.
- I/We acknowledge that the parent/guardian is responsible for protecting their password or other means of access to their e-mail sent by or received from Heritage to protect confidentiality. Heritage is not liable for breaches in confidentiality caused by the parent/guardian.
- I/We acknowledge that the use of e-mail from the parent/guardian that discusses diagnosis or treatment constitutes informed consent to the above conditions.

I/We acknowledge and understand that this e-mail consent may be revoked by me/us at any time either verbally or in writing, except to the extent that action has already been taken based upon this document having been executed.

Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

Client Signature	Date

HERITAGE SCHOOLS, INC.

g THERAPEUTIC RECREATION CONSENT g

Adolescent's Name: _____

I understand that my adolescent will have opportunities to participate in various recreational activities offered by Heritage Schools, Inc., and some activities that are considered high-risk. High-risk activities may include, but are not limited to: skiing (snow and water), white water rafting, high ropes course, and scuba diving. Heritage Therapeutic Recreation staff will contact me by telephone one week in advance to notify me of my adolescent's participation in a high-risk activity.

I understand that my adolescent will participate in the equestrian program at Heritage on a weekly basis. As this program is a part of the regular treatment plan for the adolescents there will be no notification prior to the activities associated with the program.

I understand that due to the various types of events that can occur on somewhat short notice, it is not always feasible to notify me in advance to obtain my permission for such activities as going off-campus for a meal or a movie or for participating in various low-risk sports activities. All Heritage staff have been through a background screening prior to being employed at Heritage Schools, Inc. and are required to have appropriate driving history and insurance coverage should they use their own vehicles. I understand every effort will be made to assure the safety of my child at all times.

I do hereby release Heritage Schools, Inc., its agents and employees, and any other agency (such as a referring School Board), its members, trustees, agents, officers, contractors , volunteers and employees harmless from any claims, losses, injuries (including death), costs and expenses arising (solely or in part) out of my child's participation in any such recreational programs, or for loss or damage to my child's property which may occur as a result of my child's participation in recreational activities, including the high-risk activities.

I acknowledge that I have read and understood all provisions of this "Therapeutic Recreation Consent" and agree to be bound by its terms.

Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

g VIDEO TAPING CONSENT g

I have been informed and understand that my adolescent may be videotaped for the express purpose of enhancing the quality of therapy and supervision of client's care. I, hereby, give consent for my adolescent to be video taped and for said tape to be used or viewed only under the direction of an assigned supervisor.

~ **YES** ~ **NO**

Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

g PRIVACY RIGHTS g

A copy of the "Notice of Privacy Practices" pamphlet prepared by Heritage Schools, Inc. has been provided to me.

Parent/Guardian Signature	Date	Parent-Guardian Signature	Date

ICPC 100A

One form per child
Please type

INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN REQUEST

TO:	**FROM:**
Gaye Wynn, Administrative Secretary Utah Interstate Compact Office DHS / DCFS 120 North 200 West, Suite 225 Salt Lake City, UT 84103	

SECTION I - IDENTIFYING DATA

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

Social Security Number: ICWA Eligible 9 Yes 9 No

Sex Date of Birth: Title IV-E Determination:

Ethnicity: Hispanic Origin: 9 Yes 9 No

Race:

9 American Indian or Alaskan Native
9 Asian
9 Native Hawaiian / Other Pacific Islander
9 Black / African American
9 White / Caucasian

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: Same as above

Phone: Same as above

Address:

SECTION II - PLACEMENT INFORMATION

Name of person(s) or facility child is to be placed with:
Heritage Schools, Inc.

Soc. Sec # (opt.)

Address:
5600 Heritage School Drive, Provo, UT 84604-7701

Phone:
801-226-4600

Type of Care Requested:

9 Foster Family Home
9 Group Home Care
9 Child Caring Institution
: Residential Treatment Center
9 Institutional Care-Article VI, Adjudicated Delinquent
9 Parent
9 Relative

Relationship: _____

9 **Adoption**
9 IV-E Subsidy
9 Non IV-E Subsidy

To be finalized in:
9 Sending state
9 Receiving state

Current Legal Status of Child:

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

SECTION III - SERVICES REQUESTED

Initial Report Requested (if applicable):

9 Parent Home Study
9 Relative Home Study
9 Adoptive Home Study
9 Foster Home Study

Supervisory Services Requested:

9 Request Receiving State to Arrange Supervision
9 Another Agency Agreed to Supervise
9 Sending Agency to Supervise

Supervisory Reports Requested:

9 Quarterly
9 Semi-Annually
9 Upon Request
9 Other:

Name and Address of Supervising Agency in Receiving State:

Enclosed: 9 Child's Social History 9 Court Order 9 Financial/Medical Plan 9 Other Enclosures
9 Home Study of Placement Resource 9 ICWA Enclosure 9 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 PERSUANT TO ARTICLE III(d) of ICPC

9 Placement may be made 9 Placement may not be made

REMARKS:

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

AUTHORIZATION FOR USE OR RELEASE OF PROTECTED HEALTH INFORMATION

Authorization to disclose information is granted to:

NAME OF PERSON OR ENTITY:_____

LOCATED AT_____

PHONE:_____ FAX:_____

TO RELEASE/RECEIVE THE FOLLOWING INFORMATION TO/FROM THE HERITAGE SCHOOLS, INC. PERTAINING TO:

ADOLESCENT: _____ DOB: _____

Please note that the column marked with the asterisk will allow Heritage Schools, Inc. to release this specific information back to the above as requested. This release is good for two years or sixty (60) days after discharge, whichever is later.*

Information to be disclosed:

*____		Master Treatment Plan	*____	____	Monthly Academic Report
*____		Physicians/Nurses Orders/Reports, Medical Visits	*____	____	Major Incident Report
*____		Monthly Progress Report	*____	____	Telephone Communication as necessary
*____	____	Admitting History & Physical	*____	____	Official Academic Transcripts
*____	____	Initial Assessment	*____	____	School Psychiatric/Psychological Evaluations
*____	____	Psychiatric/Psychological Evaluations	*____	____	IEP/Academic Assessments, Goals & Objectives
*____	____	Social History	*____	____	Immunization Records
*____	____	Discharge Summary with Diagnosis	*____	____	Birth Certificate
*____	____	Other_____			

Special education information to be disclosed:

*____	____	Initial Special Ed Form	*____	____	Parent Rights Document
*____	____	Permission to Evaluate Form	*____	____	Multi disciplinary Team Minutes
*____	____	Permission to Place	*____	____	Prior Notice
*____	____	Entire Special Ed. File	*____	____	Academic Testing

I acknowledge that the data to be released MAY INCLUDE material that is protected by Federal Law. My initials and my signature below authorize release of the following type of information:

_____ Drug/Alcohol Abuse Information _____ Mental Health

I understand this consent may be revoked by me at any time either verbally or in writing, except to the extent that action has already been taken based upon this document having been executed and that I will receive a completed copy of this form. I understand that I may refuse to sign this form and that Heritage Schools, Inc. will not condition treatment on whether I sign this authorization.

, All information received will be held in the strictest confidence ,

Signature of Parent/Guardian	Date	Relationship
Signature of Witness	Date	Title
Signature of Adolescent	Date	

IMPORTANT - PROHIBITION OF REDISCLOSURE

This information **is confidential** with contents protected by Federal Law. Federal Regulation (42 CRF, Part 2) prohibit one from making any further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization is **NOT** sufficient for this purpose. The Federal rules restrict any use or release of information to criminally investigate or prosecute any alcohol or drug abuse patient. Unless otherwise permitted or required by law, it is the policy of Heritage Schools, Inc. to limit disclosures of Protected Health Information to the minimum necessary to accomplish the intended purpose of the disclosure.

If you have received this information in error, please call the number below.

HERITAGE SCHOOLS, INC.

5600 N. Heritage School Drive, Provo, UT 84604-7701 Phone: 800-433-9413 Fax: 801-226-4641 or 4666

Superior Care Pharmacy, Inc., an Omnicare Company
2280 West Alexander Street, Salt Lake City, UT 84119
(801) 266-3999 (800) 345-5889 Fax (801) 685-2284

Agreement for Services

SUPERIOR CARE PHARMACY, INC. is contracted to provide the majority of the prescription medication for adolescents enrolled at the **Heritage Schools, Inc.** (3004) Superior Care Pharmacy, Inc. will bill all agencies or insurance companies when applicable. However, the guarantor or legal guardian will be responsible for any deductibles, copays, coinsurance, or non-covered charges. The following agreement must be completed, signed, and returned o Heritage prior to admission

ADOLESCENT INFORMATION (PLEASE PRINT)

Name _____ SSN _____ Date of Birth _____

Male ☐ Female ☐ Allergies _____

PAY SOURCE INFORMATION

☐ **Self-Pay** ☐ **Self-Pay with Insurance** ☐ **Medicaid ID No.** _____ ☐ **Other** _____

Insurance Company _____

Insurance Address _____ Phone _____

Policy Number _____ Group Number _____ Policy Holder _____

*****Please send a copy of the insurance card (front and back)*****

GUARANTOR INFORMATION

Name _____

Date of Birth _____ SS# _____ Relationship to client _____

Address (No PO Box #'s) _____ City _____ ST_____ Zip _____

Home Phone _____ Cell _____ Work _____ Email _____

Employer Name and Address _____

METHOD OF PAYMENT

☐ **CHARGE** my VISA, MASTER CARD, DISCOVER CARD, or AMERICAN EXPRESS account on the first day of each month.

Type of Charge Card _____ Account No. _____ Expiration Date _____

Cardholder's Signature _____ Today's Date _____

☐ **DEPOSIT** ($200.00 self-pay with no insurance; $100.00 self-pay with insurance; $50.00 Medicaid. Required at the time of admission., made payable to Superior Care Pharmacy. By signing this form I understand that I am responsible to maintain a credit balance on the account to cover future medication charges. I understand that medications will not be dispensed on a credit basis. I understand that Superior Care Pharmacy will mail a monthly itemized statement that will reflect the account balance. Should my adolescent discharge, any remaining credit balance will be refunded in full to me within 30 days from the last day of the month of discharge.

GUARANTEE OF PAYMENT

I, the undersigned, authorize Superior Care Pharmacy access to the above mentioned adolescent's medical records for proper medication assessment. I agree to pay and guarantee the prompt payment in full within 30 days for any indebtedness, obligations, and liabilities owing to Superior Care Pharmacy and/or its agents by the above-mentioned adolescent, including, but not limited to medication, medical supply, equipment, and finance or interest charges at the rate of 1.5% per month on the unpaid balance. In addition, I agree to pay and guarantee all reasonable attorney's fees, court costs, and costs of collection, with or without legal action.

GUARANTOR SIGNATURE _____ Date _____

Signer must be the same as the Guarantor listed above

Upon its completion, please fax this agreement to Superior Care Pharmacy, attention INTAKE Department.
Salt Lake Office 1-801-262-3053 or 1-800-731-3999

PLEASE RETAIN ORIGINAL SIGNATURE WITH YOUR ADMISSION RECORDS

OMNICARE - Superior Care Pharmacy

Servicing Pharmacy for Heritage Residential Treatment Center

PHARMACY SERVICES AGREEMENT AND ACKNOWLEDGEMENT

By signing the previous page (25a) of this Patient Agreement Form, the Financially Responsible Party, or his/her Legal Representative, acknowledges and agrees to the following terms:

1. **Authorization.** The Financially Responsible Party or Legal Representative hereby authorizes Superior Care Pharmacy to provide the Patient with all medications, pharmaceutical supplies, and services deemed necessary by the Patient's physician.

2. **Legal Representative.** In the event the Patient has a Legal Representative for financial matters, the Legal Representative must provide documentation to Superior Care Pharmacy proving that the Legal Representative has been granted the legal authority to access the Patient's income and resources.

3. **Assignment of Benefits.** The Financially Responsible Party or Legal Representative hereby requests and authorizes any third-party payer to make payment directly to Superior Care Pharmacy for the medications, pharmaceutical supplies, and services provided to the Patient.

4. **Payment.** The financially Responsible Party or Legal Representative is responsible for paying all charges for medications, pharmaceutical supplies, and services provided to the Patient by Superior Care Pharmacy. As a courtesy, Superior Care Pharmacy will submit claims to the insurance companies listed on the previous page (25a) of this Agreement. However, the Financially Responsible Party or Legal Representative is ultimately responsible for paying any costs not covered by insurance (other than Medicaid and some Medicare charges). Superior Care Pharmacy accepts credit card and electronic funds transfers. Payment is due within 30 days of statement date, and a finance charge equal to the lesser of 1.5% per month or the maximum annual rate permitted by law will accrue on all delinquent amounts.

5. **Collateral.** Upon Superior Care Pharmacy's request, the Financially Responsible Party or Legal Representative shall execute any documents necessary for Superior Care Pharmacy to secure collateral from the Patient or the Financially Responsible Party for payment of any amounts owed to Superior Care Pharmacy by the Patient or the Financially Responsible Party.

6. **Fees and Expenses.** The Financially Responsible Party or Legal Representative is responsible for paying all costs and expenses incurred by Superior Care Pharmacy in the collection of the amount owed and the enforcement of its rights under this Agreement, including without limitation, attorney's fees, court costs, and expenses. Venue shall be any circuit, superior, or small claims court in the State of the Financially Responsible Party or Legal Representative's residence.

7. **Termination of Services.** The Financially Responsible Party or Legal Representative acknowledges that Superior Care Pharmacy may, at its sole discretion, suspend or terminate its services to the Patient if the Financially Responsible Party or Legal Representative is delinquent on payment of Patient's account.

8. **Notice of Privacy Practices.** The Financially Responsible Party or Legal Representative acknowledges that the Patient has received Superior Care Pharmacy's Notice of Privacy Practices and agrees that Superior Care Pharmacy may disclose information from the Patient's medical and financial records to third parties in accordance with this notice.

9. **Modification.** No modification or amendment of this Agreement shall be effective unless agreed to in writing by Superior Care Pharmacy.

YOUR SIGNATURE ON THE PREVIOUS PAGE (15 a) OF THIS FORM ACKNOWLEDGES YOU NAVE READ THE TERMS OF THIS AGREEMENT AS STATED ABOVE.

LIMITED DURABLE POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, that I/We, _____
(Father/Guardian)

residing at _____ and
(Address, State, Zip Code)

_____ residing at _____.
(Mother/Guardian) (Address, State, Zip Code)

(Hereinafter "Principal(s)", being of sound mind, willingly and voluntarily and by these present, do hereby make, constitute, and appoint Heritage Schools, Inc., a Utah corporation, with a principal place of business at 5600 North Heritage Schools Drive, Provo, Utah 84603, as our true and lawful attorney-in-fact and agent (hereinafter "Attorney-in-Fact"), without substitution, for us and in our name, place, and stead and for the use and benefit of

_____ our child/ward (hereinafter "Client"), to do, perform, and accomplish all
(Adolescent)
of the following:

1. **Specific Grant of Power to Act as Custodian for Client.** In order to fully effectuate the powers specifically granted herein, the Principal(s) hereby grant to the Attorney-in-Fact full power to exercise or perform any act, power, duty, right, or obligation whatsoever that the Principal(s) now have or may hereafter acquire, relating to the Client including, without limitation, the specifically enumerated powers listed below. The Principal(s) grant to the Attorney-in-Fact full power and authority to do everything necessary in exercising any of the powers herein granted as fully as the Principal(s), jointly or separately, might or could do if personally present, with full power of substitution or revocation. The Principal(s) hereby grant to the Attorney-in-Fact full power and authority to provide all custodial care and educational and clinical services for and on behalf of the Client, to perform and accomplish all functions necessarily or reasonably related thereto, and to make health-care decisions for the Client to the same extent that the Principal(s) could make such decisions on behalf of the Client. Without limiting or qualifying the above powers delegated and assigned by the Principal(s) to the Attorney-in-Fact in the paragraph above, the Principal(s) specifically grant to the Attorney-in-Fact the following specific powers:

   a. In exercising this authority the Attorney-in-Fact shall make health-care decisions on behalf of the Client that are consistent with the desires of the Principal(s) as stated in this document or otherwise made known in writing from the Principal(s) to the Attorney-in-Fact.

   b. The Principal(s) hereby authorize all physicians and psychiatrists who have treated the Client, and all other providers of health care, including hospitals, to release to the Attorney-in-Fact all information contained in the Client's medical records which the Attorney-in-Fact may request. On behalf of the Client and themselves, the Principal(s) hereby waive all privileges attached to the physician-patient relationship and to any communication, verbal or written, arising out of such a relationship. The Attorney-in-Fact is authorized to request, receive, and review any information, verbal or written, pertaining to the Client's physical or mental health, including medical and hospital records; to execute any release, waivers, or other documents that may be required in order to obtain such information; and to disclose such information to such persons, organizations, and health-care providers as the Attorney-in-Fact shall deem appropriate. The Attorney-in-Fact is authorized to employ and discharge health-care providers including physicians, psychiatrists, dentists, nurses, and therapists as the Attorney-in-Fact shall deem appropriate for Client's physical, mental, and emotional well-being. The Attorney-in-Fact is also authorized to incur reasonable fees and expenses for such services.

c. The Attorney-in-Fact is authorized to apply for Client's admission to a medical or other similar facility; to execute any consent or admission forms required by such facility; and to enter into agreements for Client's care at such facility or elsewhere during the duration of this power. The Attorney-in-Fact is authorized to arrange for and consent to medical, therapeutical, and surgical procedures for the Client including the administration of drugs. The power to make health-care decisions for Client shall include the power to give consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

d. With the exception of corporal punishment, the Attorney-in-Fact is authorized to guide and discipline the Client as deemed necessary and reasonably by the Attorney-in-Fact.

e. The Attorney-in-Fact is authorized to physically restrain the Client should the Client become a danger to himself/herself, or to anyone else as deemed necessary by the Attorney-in-Fact.

f. The Attorney-in Fact is authorized to allow the Client to participate in various activities which commonly risk physical injury including, but not limited to, traveling, boating, water skiing, contact sports, snow skiing, snowmobiling, horseback riding, rafting, swimming, and camping.

2. **Disability or Incapacity of Principal(s).** This Limited Durable Power of Attorney shall not be affected by the disability or incapacity of the Principal(s). Any incapacity of the Principal(s) which may arise shall be deemed to have ceased to exist when certified in writing by two licensed physicians not related by blood or marriage to either the Principal(s) or any executive management personnel of the Attorney-in-Fact.

3. **Indemnification of Attorney-in-Fact.** The Principal(s) hereby ratify and confirm all that the Attorney-in-Fact shall lawfully do or cause to be done by virtue of this Power of Attorney and the powers herein granted and hereby indemnify and hold the Attorney-in-Fact harmless therefrom.

4. **Third-Party Reliance.** Third parties may rely upon the representations of the Attorney-in-Fact as to all matters relating to any power granted herein to the Attorney-in-Fact, and no person who may act in reliance upon the representations of the Attorney-in-Fact or the authority granted herein to the Attorney-in-Fact shall incur any liability to the Principal(s) or their respective estates as a result of permitting the Attorney-in-Fact to exercise any power granted herein.

5. **Substitute Attorney.** If Heritage Schools, Inc. ceases to act as the Attorney-in-Fact or otherwise fails to serve for any reason at any time, the Principal(s) hereby appoint the legal successor-in-interest of Heritage Schools, Inc. ("the successor-in-interest') as the Principal(s)' successor attorney-in-fact and Agent with all the rights and powers held by the Attorney-in-Fact. If the Successor-in-Interest ceases to act as such successor Attorney-in-Fact or otherwise fails to serve for any reason at any time, the Principal(s) shall immediately revoke this Power of Attorney and take physical custody of the Client.

6. **Duration of Power.** This Limited Durable Power of Attorney shall remain in full force and effect and continue as a valid and effective delegation of authority from and after the date of the Client's admission to the facilities of the Attorney-in-Fact and the taking of physical custody of the Client by the Attorney-in-Fact at its facilities, and shall terminate upon the earlier of: **(a)** the Client's discharge from the facilities of the Attorney-in-Fact, or **(b)** in the event the Principal(s) deliver to the Attorney-in-Fact an express written notice or revocation of this Power of Attorney, then immediately upon the Principal(s)' taking physical custody of the Client from the Attorney-in-Fact.

7. **Interpretation and Governing Law.** This instrument shall be construed and interpreted as a Limited Durable Power of Attorney. The enumeration of specific powers herein is intended to, and does limit or restrict the general powers herein granted to the Attorney-in-Fact. This instrument is executed and delivered in the State of Utah, and the laws of the State of Utah shall govern all questions as to the validity of this power and the construction of its provisions.

Adolescent's Name _____

This section to be signed in the presence of a Notary by the Father or Legal Guardian

IN WITNESS WHEREOF, the Principal _____
(Father/Guardian)

has executed this Power of Attorney on this _____ day of _____ , **2009**.

PRINCIPAL:

_____
Signature of Principal (Father/Guardian)

STATE OF _____)
:ss.
COUNTY OF _____)

On this _____ day of _____ , **2009** , _____,
(Father/Guardian)

appeared before me, _____, a notary public, to acknowledge that
(Notary)

they executed the above instrument.

_____
NOTARY PUBLIC

My Commission Expires: Residing at:

_____ _____

Adolescent's Name: _____

This section to be signed in the presence of a Notary by the Mother or Legal Guardian

IN WITNESS WHEREOF, the Principal _____
(Mother/Guardian)

has executed this Power of Attorney on this _____ day of _____ , **2009**.

PRINCIPAL:

_____
Signature of Principal (Mother/Guardian)

STATE OF _____)
:ss.
COUNTY OF _____)

On this _____ day of _____ , **2009** , _____,
(Mother/Guardian)

appeared before me, _____, a notary public, to acknowledge that
(Notary)

they executed the above instrument.

_____
NOTARY PUBLIC

My Commission Expires: Residing at:

_____ _____

ADMISSION AGREEMENT

THIS AGREEMENT is entered into this _____ (Day) day of _____ (Month) 20 **09** (Year), between

HERITAGE RESIDENTIAL TREATMENT CENTER, a Utah corporation (hereinafter called "the Treatment Center")

and _____ (Father/Guardian) (hereinafter "Sponsor") whose

address is _____ (Address, City, State, Zip Code)

and _____ (Mother/Guardian) (hereinafter "Sponsor") whose

address is _____ (Address, City, State, Zip Code).

NOW, THEREFORE, in consideration of the mutual promises of the Treatment Center and the Sponsors, the parties hereby agree as follows:

1. **Sponsors.** The Sponsors affirm that they are the legal parents/guardians of _____ (Adolescent)

(hereinafter the "Client"), whose birth date is on the _____ (Day) day of _____ (Month), 19_____ (Year), and

that they expressly desire to contract for the client's enrollment in the Treatment Center according to the terms of

this agreement.

2. **Period of Enrollment.** The Client shall be enrolled in the Treatment Center's program commencing on the

_____ (Day) day of _____ (Month), 20**09** (Year), and continuing, with the mutual consent of both

parties, until the treatment team determines the Client has successfully completed treatment. In the event the Client attains the age of eighteen (18) years before the completion to the agreed time period, then the Client's enrollment shall end the day before the Client's eighteenth (18th) birthday. In the event the Treatment Center recommends discharge of the Client because of clinical readiness or treatment plan completion, then the Client's enrollment shall end at such time as determined by the treatment staff in conjunction with the Sponsors.

In the event the Treatment Center recommends discharge of the Client because of clinical necessity, i.e., Client not responding to treatment, or continued placement in the facility is determined not to serve the Client/Sponsor/Treatment Center's best interest, or if the Treatment Center is forced to discharge the Client due to non-payment of fees (see Paragraph 7A), the Treatment Center agrees to notify the Sponsors of such intent thirty (30) days prior to the discharge.

In the event of an emergency discharge, i.e., health or safety reasons, the Treatment Center will provide a twenty-four to seventy-two (24-72) hour notice to the Sponsors of the Treatment Center's intent to discharge the Client. At the time the Treatment Center relinquishes physical custody of the Client to the Sponsors or Sponsors' agent, no additional treatment fees/charges will be incurred.

Adolescent's Name: _____

3. **Early Withdrawal of Student.** The Sponsors may withdraw the Client from the Treatment Center at any time. However, this Agreement is for an enrollment in a treatment program for the entire duration of the term specified in Paragraph #2. Accordingly, should the Sponsors voluntarily elect to withdraw the Client prior to the end of the contract period, the Sponsors shall provide the Treatment Center's business office with a written notice of intent to withdraw the Client no fewer than thirty (30) days prior to the intended date of discharge.

4. **Services Rendered by the Treatment Center.** Upon the execution of this Agreement, the Treatment Center accepts for enrollment the above-named Client and promises to undertake and provide the following services and facilities: room and board, counseling and therapeutic services for the Client and parents, educational and academic services, entrance physical and dental examinations, laundry services, nursing services (as needed), psychological and educational evaluations and assessment for the Client, personal supervision, supervised use of recreational equipment and facilities, supervised work experiences as appropriate/necessary, bookkeeping and clerical assistance with school district. Insurance and other agency forms and claims may be provided as necessary/requested.

5. **Sponsors' Consent of Participation.** The Sponsors, by their execution of this Agreement, give their informed consent for the Client to participate in all programs and activities of the Treatment Center, including but not limited to educational/therapeutic programs, work projects, training programs, and various forms of recreation and athletics except the following listed programs or activities which are not consented to:

> The Sponsors give such consent, fully accepting the risks which are associated with custodial care. These risks include but are not limited to risks that the Client's problems may not improve, risks that the Client may without permission leave the Treatment Center facility and be unattended, risk of physical injury, risk of sexual violation and pregnancy, and other risk(s) of physical or mental harm including suicide and other forms of self-injury.

6. **Limited Durable Power of Attorney.**

A. The Sponsors, simultaneous with the execution of this Agreement, shall appoint the Treatment Center as the Client's true and lawful attorney for the purpose of providing custodial care and educational and clinical services, and shall assign to the Treatment Center all of the Sponsors' powers of care and custody during the period of enrollment of the Client.

B. The Limited Durable Power of Attorney referenced in Paragraph 6A shall be effective as long as the Client is enrolled, as prescribed by Utah law. Continued enrollment of the Client is contingent upon execution of the Limited Durable Power of Attorney. Failure to execute the Limited Durable Power of Attorney will be deemed an early withdrawal of the Client according to the provisions of Paragraph 3.

Adolescent's Name: _____

7. **Financial Responsibility.**

A. Enrollment and Tuition Fees. In consideration of the services performed, _____ (Funding Source) _____ and _____ (Funding Source) will fund/co-fund for the stated length of this agreement. The monthly tuition payments are installments toward the total enrollment and tuition charges. These tuition payments do not reflect the exact number of days the Client will be a resident at the Treatment Center in any given month. Therefore, there are no fee adjustments or reduction for periods in which the absences are authorized by either the Sponsors or the Treatment Center.

B. Medical and Dental Expenses. The Sponsors shall be responsible for any and all necessary medical and dental expenses incurred for the use and benefit of the Client by reason of the procurement of medical, dental, prescription services from persons other than the treatment team. (Addendum A: Medical, Dental and Prescription Charges)

C. Clothing, Travel, Miscellaneous Expenses. The Sponsors shall pay for the following expenses as incurred by the Client: clothing, airline and other forms of commercial transportation including reasonable costs of ground transportation not associated with the regular activities and programs of the Treatment Center.

D. Property Damage and Staff Expenses. The Sponsors shall pay for any property damage or injuries caused by the Client while the Client is in the care and custody of the Treatment Center.

E. Costs of Collection. The Sponsors agree to pay the costs of collection of any amounts due under this Agreement, including reasonable attorney's fees and court costs. The Sponsors further agree that any amounts due under this Agreement, which amounts are more than thirty (30) days delinquent, shall incur a monthly finance charge in the amount of twelve percent (12%) APR.

8. **Responsibility for Injuries, Accidents, Property, or Claims.**

A. The Treatment Center assumes no liability for injuries, illness, or other damages occurring to the Client during the term of the Client's enrollment, including any resulting from the Client's participation (on or off the Treatment Center campus) in programs and activities of the Treatment Center.

B. The Treatment Center shall not be liable, financially or otherwise, for loss, damage, or theft of any of the Client's property.

C. The Treatment Center makes no representations or warranties as to the quality or quantity of education or treatment other than those made in writing and signed by an authorized Treatment Center official.

9. **Agreement Renewal.** This Agreement may be renewed with the mutual consent of the parties. Any renewal agreement shall be based upon enrollment and tuition charges and other expenses assessed at the time of such renewal.

Adolescent's Name _____

10. **Choice of Jurisdiction, Law, and General Conditions.** Sponsors, by the execution of this Agreement, submit to the jurisdiction of the Utah courts in any dispute between the parties to the Agreement. The parties acknowledge that this Agreement constitutes a business transaction within the State of Utah, which transaction is subject to the provisions of Title 78, Chapter 27, Section 24 of the Utah Code Annotated. Moreover, the parties agree that Utah law shall govern this Agreement. Failure of either party to enforce any term or provision of this Agreement shall not constitute or be construed as a waiver of such term or provision or right to enforce the same. If any provision of the Agreement is construed to be overly broad as written, the remaining provisions shall remain enforceable and any overly broad provisions shall be construed so as to narrow its application to the extent necessary to make it enforceable according to law.

11. **Initial Health Exam.** The Sponsors understand that as part of the initial lab work and physical examination, testing for HIV antibodies may be provided, upon parental request.

12. **Acknowledgment.** The Sponsors hereby acknowledge that they have read this Agreement and have understood it, and agree to all the provisions hereof.

IN WITNESS WHEREOF, the Sponsors and Treatment Center have executed this Agreement on the date below written:

Signed this _____ day of _____, 20 **09** .

SPONSORS

_____

Signature of Sponsor
(Father/Guardian)

_____

Signature of Sponsor
(Mother/Guardian)

TREATMENT CENTER

_____

Signature of Heritage Representative

ATTESTATION

In the case of only ONE parent/guardian, the following must also be signed.

I, _____ , certify that I am the sole legal parent/guardian with full legal custody of the client. Misrepresentation of such legal custody constitutes a material breach of contract and is grounds for contract termination and immediate discharge of client.

_____

Signature of Parent/Guardian

_____

Date

Addendum A

MEDICAL, DENTAL AND PRESCRIPTION CHARGES

_____, and _____ parents/
Sponsor(Father/Legal Guardian) Sponsor (Mother/Legal Guardian)

legal guardians of _____understand that they are responsible for payment
(Adolescent)

of any outpatient medical, dental and prescription costs that may be incurred by the Client during enrollment at

The Heritage Residential Treatment Center.

_____
Signature of Sponsor
(Father/Guardian)

_____
Signature of Sponsor
(Mother/Guardian)

_____
Signature of Heritage Representative

HERITAGE

Heritage Schools, Inc in conjunction with The University of New Hampshire invites you to participate in the National Association of Theraputic Schools Programs' or NATSAP study group. Please read through the following information.

NATSAP

Description of the Project

I. Introduction

The National Association of Therapeutic Schools and Programs' (NATSAP) Research Committee, chaired by John Santa, Ph.D., Montana Academy, is working with Dr. Michael Gass and graduate student Michael Young at UNH to develop and manage a data collection network designed to allow for maximum participation by NATSAP member programs. The hope is to create a deidentified aggregate database while also allowing programs to utilize their own data for treatment planning and quality improvement. The plan is for the majority of the network's data gathering to be conducted through a web-based application provided by www.carepaths.com.

II. Research Aims

- Collect aggregate outcome information that will help NATSAP communicate the nature and quality of member programs' work to stake holders.
- Allow programs access to their own data for purposes of quality improvement and treatment planning
- Organize the data into an archival database that can be accessible for approved additional research projects

III. Research Protocol

1. Overview

The network will collect data from member programs' students or clients, their parent(s) or guardian(s), as well as from program staff. Each program will have a Program Research Coordinator who will manage the study at their site. When a student or client and their family are admitted to a participating program, they will be given the opportunity to consent/assent to being part of the study.

UNIVERSITY of NEW HAMPSHIRE

PARENT/GUARDIAN RESEARCH CONSENT FORM

Heritage Schools, Inc., in conjunction with NATSAP Research and Evaluation Network is participating in a study called the **"NATSAP Research and Evaluation Network." "NATSAP" stands for: National Association of Therapeutic Schools and Programs (www.natsap.org).** Heritage is a member of this organization. The University of New Hampshire will compile the information for the study. You are invited to participate with your adolescent in this research study to improve the quality of care for adolescence in treatment. This is a completely confidential and anonymous study. There is no cost to you.

WHAT DOES YOUR PARTICIPATION IN THIS STUDY INVOLVE?

You will be asked to fill out questionnaires about your perception of your adolescent's behavior and overall mental health. You will receive instructions to fill out the initial survey. These questionnaires will take you about 15 minutes and you will be asked to fill them out at three different times: when your adolescent admits, discharges from the program, and again one year after. You can fill these forms out on the internet and you will get e-mail reminders and instructions after your adolescents discharge. Paper forms may be used instead if you do not have internet access. The forms and instructions can also be mailed to you if necessary. Your adolescent will be asked to fill out similar forms.

WHAT ARE THE POSSIBLE BENEFITS OF PARTICIPATING IN THIS STUDY?

This study is designed to help Heritage improve the quality of care. Your participation could also help other adolescents who will attend the program in the future. If you choose not to be part of the study, it will not affect your adolescents program at Heritage.

CAN YOU WITHDRAW FROM THIS STUDY?

You are free to withdraw from the study at any time without prejudice, penalty, or loss of benefits to which you are otherwise entitled.

CONTACT INFORMATION IF YOU HAVE QUESTIONS ABOUT THIS STUDY

If you have any questions pertaining to the research you should feel free to contact a research coordinator at Heritage, Brenda Norman at: (801)226-4655 or brenda.norman@heritagertc.org, or a research coordinator at UNH Michael Young at: (603)862-2007 or michael.young@unh.edu, or questions about your rights as a research subject you can contact Julie Simpson in the UNH Office of Sponsored Research, 603-862-2003 or Julie.simpson@unh.edu to discuss them.

If you have read these statements, understand them, and consent to participate, please sign below:

_____

Client/Student Name

_____ _____

Parent/Guardian Signature Date

Heritage Schools, Inc. In conjunction with NATSAP Research and Evaluation Network and UNH

HERITAGE NATSAP UNIVERSITY of NEW HAMPSHIRE

HERITAGE NATSAP

PARENT/GUARDIAN CONSENT FORM

TITLE OF RESEARCH STUDY

You are invited to participate in a research study called the NATSAP Research and Evaluation Network. "NATSAP" stands for: National Association of Therapeutic Schools and Programs (www.natsap.org). The program your child is enrolled at is a member of this organization.

WHAT IS THE PURPOSE OF THIS STUDY?

This study is designed to measure how your child is helped by his/her program. The study should be able help the program to improve its services.

WHAT DOES YOUR PARTICIPATION IN THIS STUDY INVOLVE?

- You will be asked to fill out 2-3 questionnaires about your perception of your child's behavior and overall mental health
- Filling out these questionnaires will take you about 15 minutes
- You will be asked to fill them out at three different times:

  1) When your child is admitted to the program
  2) When your child graduates or leaves the program
  3) One year after your child graduates or leaves the program

- You can fill these forms out on a computer at a website that has been set up for the study. You will get e-mail reminders and instructions that will help you to do this. The forms and instructions can also be mailed to you if necessary.

- If your child is 11 or over, they will be asked to fill out similar forms at these three times as well.

WHAT ARE THE POSSIBLE RISKS OF PARTICIPATING IN THIS STUDY?

There are no physical risks. You may feel some discomfort or embarrassment when you share personal information about your child or family. You should feel free to talk about any discomfort you feel with staff from your child's program. You may withdraw from the study at any time.

WHAT ARE THE POSSIBLE BENEFITS OF PARTICIPATING IN THIS STUDY?

- This study is designed to help your child's program get better at helping children. Your participation could help other children who will attend the program in the future.
- It is possible that the program will use the information gathered from you and/or your child to help them create a treatment plan
- *If you choose not to participate your child will still have access to every other aspect of the program and treatment that they would have otherwise.*

IF YOU CHOOSE TO PARTICIPATE IN THIS STUDY, WILL IT COST YOU ANYTHING?

There is no cost to you

WHAT OTHER OPTIONS ARE AVAILABLE IF YOU DO NOT WANT TO TAKE PART IN THIS STUDY?

- You understand that your consent to participate in this research is entirely voluntary, and that your refusal to participate will involve no prejudice, penalty or loss of benefits to which you would otherwise be entitled.
- Your child will still have access to every other aspect of their program and treatment.

CAN YOU WITHDRAW FROM THIS STUDY?

If you consent/agree to participate in this study, you are free to stop your participation in the study at any time without prejudice, penalty, or loss of benefits to which you would otherwise be entitled

HOW WILL THE CONFIDENTIALITY OF YOUR RECORDS BE PROTECTED?

The University of New Hampshire and your child's program seek to maintain the confidentiality of all data and records associated with your participation in this research.

You should understand, however, there are rare instances when the researcher is required to share personally-identifiable information (e.g., according to policy, contract, regulation). For example, in response to a complaint about the research, officials at the University of New Hampshire, designees of the sponsor(s), and/or regulatory and oversight government agencies may access research data.

You also should understand that the researcher is required by law to report certain information to government and/or law enforcement officials (e.g., child abuse, threatened violence against self or others, communicable diseases).

All the forms that are filled out at the study website will be stored securely and accessible by approved program staff and the University of New Hampshire research coordinators through password access only. When the information is made available to other researchers, it will be stripped of anything that would identify it as yours or your child's.

If paper forms are used, they will be locked securely at your child's program after they have been entered into the computer-based system described above.

WHOM TO CONTACT IF YOU HAVE QUESTIONS ABOUT THIS STUDY

If you have any questions pertaining to the research you should feel free to contact your child's program, or a UNH research coordinator at michael.young@unh.edu, mgass@unh.edu, or at (603)862-2007.

If you have questions about your rights as a research subject you can contact Julie Simpson in the UNH Office of Sponsored Research, 603-862-2003 or Julie.simpson@unh.edu to discuss them.

If you have read these statements, understand them, and consent to participate, please sign below:

_____

Client/Student Name

_____ _____

Parent/Guardian Signature Date

HERITAGE