Admission Information for Parents

Contacting your daughter

For the first month, you will be contacting your daughter by mail only and receiving weekly updates from your daughter’s primary therapist. After that first month, upon therapist approval, you will be able to communicate by phone with your daughter each week in a “social call”. Also, after that first month, you will be in contact with your daughter and her therapist through weekly, family therapy sessions via phone or other tele-therapy methods. You are always encouraged to call for updates as often as you would like.

Contacting the Renewed Hope Ranch Facility:

By phone: 435-531-0040
By mail: Renewed Hope Ranch
By email: steve@renewedhoperanch.com
425 East 6000 North
Enoch, UT 84721

Contacting your Renewed Hope Ranch Team

Primary Therapist: Stephen C. Barrick, CMHC
By phone: 435-592-0558
By email: steve@renewedhoperanch.com

Residential Directors: Ellayna LeFevre
By phone: 435-558-9320
By email: ellayna@renewedhoperanch.com
Makayla Gishi
By phone: 435-592-9835
By email: makayla@renewedhoperanch.com

Office Manager: Nadine Barrick (M-F, 8-5 PM, MST)
By phone: 435-531-0040
By email: office@renewedhoperanch.com

Academics (Principal): Allen Garrett (5-7 PM, MST)
By phone: 435-559-2844
By email: school@renewedhoperanch.com

Admissions: Natalie Stefanoff
By phone: 435-680-0313
By email: natalie@renewedhoperanch.com

After Hours Cell: Shift Supervisor
By phone: 435-531-9964
Information Reviewed at Admission

______ I have received a Parent Handbook and Resident Handbook
______ I know how to contact my daughter at Renewed Hope Ranch
______ I know how to contact the Team at Renewed Hope Ranch
______ I have been informed of the typical contact procedures for phone calls, mail, and visits
______ I have a schedule for upcoming Parent Weekends
______ I know how to contact Renewed Hope Ranch in an emergency or after hours
______ I have completed an approved Contact List for my daughter’s contacts
______ I understand that my daughter will have a physical and lab work completed as part of admission
______ I have discussed any medical, personal, or special needs of my daughter
______ I have completed the Admission Paperwork, and received a copy after completing signatures
______ I understand the billing process, early termination policy, and where to direct billing questions

Parent Signature ___________________________________________ Date _____________
Parent Signature ___________________________________________ Date _____________
Admission Signature _________________________________________ Date _____________
# Application for Residential Treatment

## Parent Guardian Information

<table>
<thead>
<tr>
<th>Parent/Guardian Name:</th>
<th>Relationship:</th>
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<tbody>
<tr>
<td>Home Address:</td>
<td>Date of Birth:</td>
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<tr>
<td>City, St., Zip:</td>
<td>SSN:</td>
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<tr>
<td>Home phone:</td>
<td>Occupation:</td>
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<td>Cell phone:</td>
<td>Annual Salary:</td>
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<td>Work phone:</td>
<td>Marital Status:</td>
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<td>Email:</td>
<td>Custody Status:</td>
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## Parent Guardian Information (Additional)

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<td>Marital Status:</td>
</tr>
<tr>
<td>Email:</td>
<td>Custody Status:</td>
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</tbody>
</table>
Referral Information

How were you referred to Renewed Hope Ranch?
☐ Ed. Consultant
☐ Adoptions Assist
☐ Family Therapist
☐ School District
☐ Website
☐ Wilderness Program
☐ Psychiatric Facility
☐ Treatment Program
☐ Diversion Program
☐ Other _____________

Financial Information

What financial arrangements will be in place for the cost of treatment?
☐ Private Pay
☐ Insurance
☐ Trust Account
☐ Financing / Loan
☐ Adoptions Assistance Funding _________________________ (county, state)
☐ IEP Funding _________________________________________ (school district)
☐ ILWU _____________________________________________ (representative)
☐ Other ______________________________________________ (please indicate source)

Are there any special circumstances that we need to be aware of or additional information we can provide to better assist you in working with treatment costs? (Pre-certification for insurance, documentation of services, unique financial situations, etc.)
________________________________________________________________________________________________________
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Resident Information

Resident's full name ____________________________ Height ___________
Nickname (if any) ___________________________________________ Weight ___________
Social Security Number ____________________________ Hair Color ___________
Date of Birth ____________________________ Age Now ____________________________ Eye Color ___________
Is resident adopted  □ Yes  □ No  Gender (circle one):  M  |  F  Shirt Size ____________________________
Grade in school ____________________________ Age at adoption ____________________________ Shoe size ___________
Physical marks (tattoos, piercing, scars) __________________________________________________________
Resident lives with ______________________________________________________________
Religious preference ______________________________________________________________
Ethnic background ______________________________________________________________

Please specify current medical needs or information pertaining to the resident’s daily care:

________________________________________________________________________________________
List any limitations or accommodations regarding the resident’s ability to participate in day to day activities:

________________________________________________________________________________________

Please indicate unique needs pertaining to personal, religious or cultural practices: (including requirements or restrictions to diet, activities, etc.)

________________________________________________________________________________________

List resident’s strengths, talents, abilities: ______________________________________________________
List resident’s difficulties or insecurities: _______________________________________________________
Have developmental milestones been achieved at appropriate ranges? (crawling, walking, talking, social interaction)

________________________________________________________________________________________

Current medications:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose (mg)</th>
<th>Medication Name</th>
<th>Dose (mg)</th>
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</table>
Current clinical, emotional and behavioral diagnosis / issues. Check all that apply:

- Depression
- Mood Disorder
- Suicidal thoughts or talk
- Sexual acting out
- Anxiety
- Autism Spectrum Disorder
- Suicidal plans or attempts
- Sexual Identity issues
- Bipolar
- Attachment / Adoption
- Physical abuse victim
- Gambling
- ADHD
- Substance Abuse / Addiction
- Sexual abuse victim
- Stealing / Shoplifting
- Oppositional Defiant
- Eating Disorder / Body Image
- Cutting or Self-harm
- Bedwetting
- Obsessive Compulsive
- Trauma / PTSD
- Internet / Gaming
- Runaway history
- Borderline (BPD)
- Social fears or phobia
- Pornography
- Other:_____________

Describe specific behaviors that have led to the need for placement: _____________________________________________________________

Is the resident aware treatment is being considered? __________________

Is there an immediate need for placement? _________________________

List any concerns you have with getting your resident to treatment: ____________________________________________________________

History

Resident lives with:
Status of parent’s relationship:  □ Married / intact  □ Divorced  □ Separated  □ Remarried
Custody status (if applicable): □ Intact  □ Sole  □ Joint  □ Guardian (please attach supporting documentation, if applicable)
Is resident adopted?  □ Yes  □ No  □ Is contact maintained with birth parents?  □ Yes  □ No
If “Yes”, Age at adoption ______
If adopted, brief history of prior care and parental involvement: ____________________________________________________________

Describe the relationship the resident has with parents: _________________________________________________________________

Describe the relationship the resident has with siblings: _______________________________________________________________

Estimate the number of hours the resident spends each week on the following:

_____ Time with parents  _____ Boyfriend / Girlfriend  _____ Sports / Hobbies  _____ Internet
_____ Time with siblings  _____ Time alone  _____ Clubs / Groups  _____ Video games
_____ Time with friends  _____ Studying / Schoolwork  _____ Job / Volunteer  _____ Other:

List family history of emotional / mental health issues: _________________________________________________________________

List family history of alcohol / substance abuse: ________________________________________________________________

Are any family members currently receiving treatment? _______________________________________________________________

Do any family members need assistance seeking mental health, alcohol or substance abuse treatment?  □ Yes  □ No
List family members, age, and relationship:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
<th>Lives in home?</th>
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</table>

Treatment Goals
What specific issues need to be addressed in treatment?
What skills or goals do you hope for the resident to achieve?
What are your goals for the family during treatment?
How can we support you through the treatment process?

Treatment History
Provider__________________________Provider__________________________
Location__________________________Location__________________________
Phone____________________________Phone____________________________
Date of services____________________Date of services____________________
Reason for service__________________Reason for service__________________
Will provider continue services after treatment?________Will provider continue services after treatment?________

Provider__________________________Provider__________________________
Location__________________________Location__________________________
Phone____________________________Phone____________________________
Date of services____________________Date of services____________________
Reason for service__________________Reason for service__________________
Will provider continue services after treatment?________Will provider continue services after treatment?________

Medical Information
Describe any immediate medical or dental needs
Describe resident’s general health
List past medical conditions:
List any medication reaction / sensitivity / allergy:
Date of last medical exam:________________Date of last dental exam:________________
List any known allergies:
List any major injury, surgery or illness, physical trauma:
Are there any medical or physical limitations that would prohibit regular participation in daily activities?
☐ Yes ☐ No (please describe)__________________________________________________
Indicate required use of glasses, contacts, braces, hearing aids, or require orthopedic devices
List any special dietary needs: (food allergies, vegetarian diet, religious restrictions, etc.)

Previous Health Care Providers

Medical
<table>
<thead>
<tr>
<th>Provider</th>
<th>Address</th>
<th>City, St., Zip</th>
<th>Phone</th>
<th>Month / Year</th>
<th>Specialty</th>
<th>Reason for service</th>
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Dental
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<th>Provider</th>
<th>Address</th>
<th>City, St., Zip</th>
<th>Phone</th>
<th>Month / Year</th>
<th>Specialty</th>
<th>Reason for service</th>
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</table>

Other
| Provider | Address | City, St., Zip | Phone | Month / Year | Specialty | Reason for service |
**Medication History**

List current and previous medications, indicating effectiveness or complications of each medication in the comment section.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage &amp; Frequency</th>
<th>Indicate Current Use or Date Discontinued</th>
<th>Comments</th>
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**Academic History**

Current School ___________________________________________
Address ________________________________________________
City, State, Zip _________________________________________
Phone ___________________________________________________
School District _________________________________________
Counselor _______________________________________________

Current Grade Level ______________________________________
Approx. GPA _____________________________________________
Credit deficient? _________________________________________
Failing any current courses? ______________________________
Failed any grade level? _________________________________

Current academic needs ___________________________________
Does the resident have an IEP or receive Special Education services? ____________________________________________
Describe any accommodations or special support in the classroom _____________________________________________
Describe the resident’s level of functioning; at or above grade level, honors or remedial courses ____________________________
Favorite class / subject ___________________________________
Least favorite class / subject ______________________________
Has there been a recent problem with absences / truancy? ______________________________________________________
Has the resident ever been suspended or expelled? If yes, please explain: __________________________________________

Is the goal for the resident to earn a high school diploma while enrolled at Renewed Hope Ranch?  □ Yes  □ No  □ Unsure
Additional information or concerns: ________________________________________________________________

**Behavioral History**

Is your child respectful of authority: parents, school advisors, authority figures? _____________________________
Does your child have truancy issues, suspensions or expulsion from school? ________________________________
Does your child display aggressive or violent behaviors at home? _________________________________________
Has your child displayed hostile, aggressive or violent behavior with peers? ______________________________
Describe any run-away behavior; duration, location, was contact maintained: _______________________________
Has your child been arrested or charged with a crime? _________________________________________________
Does your child have a history or stealing or shoplifting? _____________________________________________
Does your child have a history of damaging property? _________________________________________________
Does your child have a history / fascination with fire? ________________________________________________
**Social History**
Describe peer relationships and number of long term friends

Does your child isolate from peers or is known as a loner?  

Is your child inclined to be leader or follower in peer groups? 

Does your child generally feel accepted or rejected by peers? 

Do parents typically approve of peer group? 

Difficulty or awkwardness connecting to peers?  

Does your child tend to gravitate toward younger, same age, or older peers? 

Does your child participate in extra-curricular activities, hobbies, or sports?  

Is your child sexually active? ☐ Yes ☐ No 

Is your child in a serious or long term relationship? ☐ Yes ☐ No 

Describe any risky or inappropriate sexual behavior (sexual acting out, promiscuity, explicit sexual communication / photos shared electronically, etc.) 

**Emotional History**
Describe any traumatic event (Physical or sexual abuse, rape, violence, loss, death of a loved one, grief) 

Describe any major change of environment (Divorce, separation, relocation, new home, new school) 

Describe any depressive symptoms, isolation, or mood swings 

Describe any bizarre or unusual behaviors; hallucinations or delusion 

Describe any low self-confidence, self-esteem, or significant insecurities 

Describe any history of self-harm; cutting, self-infliction 

Details of expressed suicidal thoughts or gestures 

Details of any suicide plans or attempts, include date 

Describe emotional outburst, out of control behavior 

Describe any eating disorder behavior (Binging, purging, restricting, use of diuretics) 

Describe any struggle with attentiveness, completing tasks, impulsivity 

Does the resident have history of bedwetting? 

**Spiritual / Religious History**
Does your child have a religious preference? Please list affiliation: 

Does your child attend church activities, participate in youth groups? 

Does your child believe in a higher power? 

Are parents supportive of child’s beliefs and participation in chosen faith? 

Are any accommodations or restrictions pertaining to religious or spiritual beliefs? 

Additional information or concerns:

*Bible study and visits from clergy are not part of the treatment program but are available to interested residents with parental consent. Reasonable accommodations will be considered through the Treatment Team. We do not have a religious affiliation.*
**Additional Information**

List any additional information we should be aware of regarding the individual needs of your child or family:

____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

**Substance Abuse History**

Current alcohol or substance use:

<table>
<thead>
<tr>
<th>Substance</th>
<th>Frequency of use</th>
<th>Amount each use</th>
<th>How long in use</th>
<th>Age at first use</th>
</tr>
</thead>
<tbody>
<tr>
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Within the last 6-12 months, list known or suspected use / abuse of:

- Used street drugs – indicate substance
- Prescription drugs – indicate substance, not to include prescribed meds
- Over the counter medication – indicate substance
- Used aerosol products, other spray products to get high – indicate substance

- Consumed alcohol
- Was observed drunk, high, or hung-over
- Cigarettes. Amount per day ________________________________
- Overdosed or treated for drug abuse or alcoholism
- Arrested or legally charged for possession or use of drugs or alcohol – detail _____________________________

Check the following behaviors that are directly or indirectly related to your child’s substance abuse:

- Truant from school
- Failed school classes or grades
- Suspended or expelled
- Uses drugs or alcohol due to learning disabilities / difficulties with school work
- Abandoned positive friendships for more negative ones
- Onset or increased sexual activity
- Uncharacteristically withdrawn, isolated, or depressed
- Uncharacteristically paranoid, suspicious, irritable, or volatile
- Attempted or threatened suicide or serious self-harm
- Uncharacteristically belligerent, angry, or defiant
- Involved with dangerous, impulsive or risky behavior
- Aggression, assault, fighting with family or peers
- Defiant to teachers, parents, and authority figures
- Sleep patterns have noticeably changed
- Unable to meet responsibilities normally expected
- Runs away from home and/or remains gone for extended periods
- Violates family rules, values, and standards
- Increased health problems
- Sexually transmitted disease
- Became pregnant / impregnated
- Uncharacteristic loss of memory, difficult remembering things, or thinking through decisions
If your child is known to be abusing drugs or alcohol, please check any statement that applies:

- Has increased amount or frequency of drugs/alcohol
- Has made promises to stop or tried to cut down but has not been able to do so
- Continues to abuse drugs or alcohol despite continuing or worsening problems.
- Immature, lacks judgment, or responsibility
- Puts self down; self-defeating behavior
- Lies even when there isn’t a need to
- Lies to cover up her mistakes, failings, or weaknesses
- Seeks status by being a negative or delinquent leader
- Doesn’t make own decisions; easily controlled by others
- Doesn’t stand up for values or beliefs or what she knows is right
- Easily influenced into delinquent acts to please/impress
- Doesn’t think twisting the truth is lying
- Cannot stand criticism or disagreement with her ideas
- Intimidates bullies, pushes people around
- Feels that it’s alright to steal if she doesn’t get caught
- Feels that it’s alright to steal if she doesn’t get caught
- Drinks or uses drugs to get or keep friends
- Lacks confidence that she can get things on her own efforts
- Doesn’t respect others; willing to hurt another to get her way
- Steals to prove she isn’t afraid or weak, that she’s cool or tough
- Steals to prove she isn’t afraid or weak, that she’s cool or tough
- Seals to prove her importance or worth
- Feels that it’s alright to steal if she doesn’t get caught
- Feels that it’s alright to steal if she doesn’t get caught
- Seems to not care about damaging or hurting herself with drugs
- Doesn’t stand up for values or beliefs or what she knows is right
- Lies even when there isn’t a need to

Problem Behavior Information

Positive Peer Culture (PPC) delivers a conflict-resolution approach and is the managing therapeutic model throughout the milieu. This methodology facilitates an atmosphere of kindness, firmness, dignity and respect in which adolescents can best learn responsibility. PPC is solution oriented, which gives the teen experience in problem solving personal and group issues as well as developing responsibility for their actions and accountability to the group as a whole. The 12 behavior systems identified in the PPC model are listed below. Please indicate (X) each behavior symptom below that describes your teen.
Request for Records
Request, Release and Exchange of Verbal and Written Information

I, _______________________, the legal parent or guardian of ______________________ authorize Renewed Hope Ranch to request and receive records and information pertaining to medical, clinical, and educational information, including dates of service or enrollment, course of treatment, diagnosis, treatment and discharge information, counseling notes, substance abuse treatment, academic records, referral for treatment and correspondence with insurance.

(Parent Signature) ____________________
(Date) ____________________

A Separate Request is Required for Each School, Facility or Provider

Name of Client ______________________________________
Date of Birth ______________________________________
Approx. Service Dates ______________________________________

Name of Facility: ______________________________________
Name of Provider: ______________________________________
Phone Number: ______________________________________
Fax Number: ______________________________________

Requested Information

___Transcripts, Academic and IEP Records & Testing
___History and Physical Examination, Lab Reports
___Medication Reports
___Psychological Testing

___Treatment History, Plan, Discharge Summary
___Referral for Residential Treatment
___Insurance Information
___Other: ______________________________________
I request contact with my insurance on my behalf to determine the possible benefits that may be applicable for services for my child at Renewed Hope Ranch. I understand that approval of services by insurance provider is not a guarantee of such benefits or payment, and acknowledge that I am responsible for timely payment of charges. Any insurance benefits received will be applied to my account and funds remaining after the treatment period is completed will be refunded to me. Please attach copies of front and back of insurance card.

(Signature of policy holder)  (Date)

Resident Information
Resident Name: _______________________________ Age_________ Date of Birth_______________________
Current Diagnosis: ________________________________________
Current Medications: ___________________________________________________________________________________
Reason for residential placement: (List current symptoms, events and behaviors. Detailed categories included on next page)

Prior Hospitalization: Month/Year: __________ Reason for Admission:_______________________________
☐ Yes ☐ No Facility: _____________________________ Length of Stay: __________
Prior Treatment Program: Month/Year: __________ Reason for Admission:_______________________________
☐ Yes ☐ No Facility: _____________________________ Length of Stay: __________
Prior Psychiatry or Therapy: Month/Year: __________ Reason for Admission:_______________________________
☐ Yes ☐ No Facility: _____________________________ Length of Stay: __________

Detailed Events and Behaviors
Suicidal talk, plan or attempt: ☐ Yes ☐ No Detail_______________________________
Substance Addiction / Abuse: ☐ Yes ☐ No Detail (frequency, amount duration of substances used)_____________________
Drug, alcohol or medication ☐ Yes ☐ No Detail (overdose?)_______________________________
Eating Disordered Behavior: ☐ Yes ☐ No Detail_______________________________
Uncontrollable/Unmanageable Behavior: ☐ Yes ☐ No Detail_______________________________
Victim of physical or sexual abuse/trauma: ☐ Yes ☐ No Detail_______________________________
Danger to self or others: ☐ Yes ☐ No Detail_______________________________
PRIMARY INSURANCE

Resident Name ____________________________________________ Date of birth __________________________
Name of Insured __________________________________________ Date of birth __________________________
Insured’s address ___________________________________________ Insured’s home phone ______________________
City, St., Zip __________________________________________ Insured’s cell number ______________________
Name of Provider ___________________________________________ Provider phone ______________________
Policy or Plan # __________________________________________ Group number ______________________
Employer ____________________________________________________________________________________________

Resident Name ____________________________________________ Date of birth __________________________
Name of Insured __________________________________________ Date of birth __________________________
Insured’s address ___________________________________________ Insured’s home phone ______________________
City, St., Zip __________________________________________ Insured’s cell number ______________________
Name of Provider ___________________________________________ Provider phone ______________________
Policy or Plan # __________________________________________ Group number ______________________
Employer ____________________________________________________________________________________________

TREATMENT PROVIDERS (not listed on page 1)

Provider: ____________________________ Month / Year: ________ Duration: __________
Reason for Treatment: ____________________________ ____________________________ ____________________________ ____________________________

Provider: ____________________________ Month / Year: ________ Duration: __________
Reason for Treatment: ____________________________ ____________________________ ____________________________ ____________________________

Provider: ____________________________ Month / Year: ________ Duration: __________
Reason for Treatment: ____________________________ ____________________________ ____________________________ ____________________________

Provider: ____________________________ Month / Year: ________ Duration: __________
Reason for Treatment: ____________________________ ____________________________ ____________________________ ____________________________

NOTES / ADDITIONAL INFORMATION:

__________________________________________________________________________________________
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(Signature of Parent / Guardian)
________________________________________
(Print Name) ____________________________________
<table>
<thead>
<tr>
<th>Date:</th>
<th>Rep:</th>
<th>Name of Ins. Rep:</th>
<th>Call back number:</th>
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Eligible for benefits?  □ Yes  □ No  Can any benefits be converted for treatment?  □ Yes  □ No

Exceptions or non-eligible due to:

<table>
<thead>
<tr>
<th>Eligible Coverage:</th>
<th>□ Out of Network</th>
<th>□ Unlimited</th>
<th>□ Limited to _______ days covered @ ________% per calendar year</th>
</tr>
</thead>
</table>

Deductible?  □ Yes  □ No  Amount $_______  □ Per admission  □ Per calendar year  Calendar year ends:____________________

Pre-certification required  □ Prior to Admission  □ Within 24 hours or admission  Date Pre-certification completed:

**Admissions checklist:**
Placement Agreement

This Agreement, dated the _______ day of ______________, year ___________, is between Renewed Hope Ranch, LLC, hereinafter, “RHR”, and ________________________________________, hereinafter, “the Sponsor(s)”, residing at ___________________________
___________________________________ the Sponsor(s), hereinafter, “the Parties”, agree as follows:

Please initial each numbered section and bottom of each page of contract. Notary is required.

1. SPONSORS.    The sponsors affirm that they are the parent or legal guardian of _________________ (hereinafter “the Patient”) whose date of birth date is the _______ day of ________________, year __________ and that they expressly desire to contract for his / her admission in the School according to the terms of this Agreement. RHR shall be entitled to rely on the representations of either of the above-named Sponsors with respect to the Patient, regardless of whether the term “Sponsor” appears in this Agreement in the singular or the plural.

2. ADMISSION OF PATIENT.     Upon the completion of this Agreement, RHR agrees to review for admission the above-named Patient and to provide the following services: room and board; academic services; and therapy services. Once admitted, the Resident will receive an initial psychiatric assessment, a well-resident exam, which includes a physical pain assessment, drug testing, blood draws and labs, mental health status exam and medication management. For a description of additional billable services that exceed those listed above, please see section 4.b. which outlines additional costs and expenses. All costs associated with treatment are the responsibility of the Sponsor. As a courtesy, RHR will submit billable services to the insurance provider indicated by the Sponsor.

3. CONTRACT PERIOD.     This Agreement will begin the ________ day of ______________, year ___________, and shall be renewed automatically on a month-to-month basis, unless either party terminates this Agreement by giving written notice to the other party as outlined in Sections 8.a. and 8.b. All patients accepted for admission are accepted on the condition that they will complete individual education and treatment goals.

4. FINANCIAL PROVISION.
   a. ROOM AND BOARD, THERAPY, AND TREATMENT CHARGE.     The monthly rate for services described under section 2 above shall be: $_________ to include services listed in paragraph 2 of this contract. An initial placement fee of $_________ shall be paid upon admission. **Initial 30 day tuition and placement fee are due upon admission and is non-refundable.**
   b. ADDITIONAL COSTS AND EXPENSES.     Costs and expenses not covered by RHR are the responsibility of the Sponsor and will be billed as appropriate and eligible. These costs may include: additional psychiatric management and consultation, all prescription medication, all dental and medical examinations, physical exams, nursing services, additional drug screens, pain assessments, blood draws and labs, hearing exam, vision exam, routine and emergency dental exams and treatments, routine and emergency medical treatment, diagnostics, transcription and interpretations, pregnancy testing, screening for STDs or pelvic exam, extended academic or psychological testing, transportation to and from RHR for admission, discharge or routine home visits; and specialized or extracurricular athletic, recreational or other enrichment activities outside of normal programming that may include equipment and/or fees.
   c. PAYMENT SCHEDULE.     Charges described under 4.a. are payable one month in advance; charges in 4.b. will be billed separately and shall be due and payable at the end of each month. If financial arrangements are being considered, a minimum of 70% of the monthly tuition is required by due date.
   d. ANNUAL RATE INCREASE.     The daily rate described under 4.a. and 4.b. shall be subject to annual increase.
   e. RESPONSIBILITY FOR DAMAGE TO PROPERTY BY THE PATIENT.     Sponsors agree to be financially responsible for the costs of repairing or replacing any RHR property or person, or for replacement of any property belonging to others which may be located at the facility which has been damaged, defaced or destroyed by the Patient, or for any damage resulting from injury to third person caused by the Patient.
   f. EXPENSES FOR THE ASSISTANCE IN THE RETURN OF RUNAWAY PATIENT.     In the event that the Patient becomes a runaway, either from RHR or elsewhere, RHR will use reasonable efforts to assist the Sponsors in finding the Patient and in
obtaining the safe return of the Patient to RHR. An accounting of the expenses incurred by RHR while assisting the Sponsors in finding and returning the Patient to RHR will be made to the Sponsors. Sponsors will be responsible for one-half of such expenses.

g. RESPONSIBILITY FOR LOSS OR DAMAGE TO THE PATIENT’S PROPERTY. RHR is not liable financially or otherwise, for loss, damage, or theft of any of the Patient’s property.

h. COST OF COLLECTION; ATTORNEY FEES. Sponsors agree to pay the cost of collection of any amounts past due under this agreement for in excess of 30 days, including reasonable attorney’s fees. Sponsor also agrees to pay 18% per annum on any unpaid balance both before and after judgment.

5. RESPONSIBILITY FOR INJURIES OR ACCIDENTS. RHR is not liable for any injuries, illness, or other damages occurring to the Patient during the term of admission, including any resulting from the Patient’s participation (on or off RHR’s property) in programs and activities of RHR or as may be caused by the negligence of RHR or its agents, employees, representatives, or contractors.

6. RELEASE OF RECORDS. RHR shall release the Patient’s transcript and records to other facilities upon the specific request of the Sponsors. Official transcripts, records of academic credits, medical records, clinical records and discharge summaries shall NOT be released until all amounts owing RHR under this Agreement at the time of the request shall be paid in full.

7. CHOICE OF JURISDICTION, LAW, AND OTHER MATTERS. Sponsors agree to be subject to jurisdiction of Utah Courts in any dispute between the parties to this Agreement, and the venue shall be Iron county, Utah. The parties agree that this Agreement constitutes a business transaction in subject to the provisions of Title 78, Chapter 27, and Section 24, of the Utah Code Annotated 1953 and as amended. 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 the right to enforce it. If any provision of the Agreement is construed to be overbroad as written, the remaining provisions shall remain enforceable according to applicable law.

8. EARLY ENROLLMENT TERMINATION:
   a. TERMINATION BY SCHOOL. RHR reserves the right to terminate this Agreement at any time upon seven (7) days advance notice to Sponsors. In the event of such termination by RHR, RHR shall refund such portion of the charge which has been paid by Sponsors for the period following discharge.
   b. WITHDRAWAL BY SPONSORS. Sponsors retain the right to terminate the Agreement at any time without penalty after thirty (30) days advance written notice to RHR. In the event Sponsors withdraw the Patient prior to completion of Treatment Plan without thirty (30) days notice, Sponsors shall pay RHR one (1) installment of the monthly charge. The equivalent of one monthly installment is considered by the Parties to this agreement as a reasonable pre-estimate of the probable losses which would be sustained by RHR in the event of a withdrawal of the Patient prior to completion of Treatment Plan. This “loss” amount is not considered by either of the parties to the Agreement as a penalty for early withdrawal of the Patient. Instead, because the cost amounts of such items as contracted staff salaries, incurred debt reduction, staff schedules, inventories, operating expenses, etc., are so difficult or impossible to accurately estimate, the one (1) month payment equivalent appears to each of the Parties as a reasonable estimate of RHR’s losses associated with early withdrawal of the Patient.

9. OTHER HEALTHCARE PROVIDER PROVISION. The undersigned agree(s) that in the event that other healthcare professional providers, including but not limited to other hospital(s), furnish services to the Patient while at RHR, the consent(s), assignment(s), guarantee(s) and release(s) herein above set out apply to such other providers and services.

10. SCOPE AND MEANING OF AGREEMENT. Sponsors hereby acknowledge that they have read the Agreement and that they understand and assent to its provisions. This Agreement constitutes the entire Agreement between the Parties except as may be noted by attached Addendum when appropriate.
11. THIRD PARTY FUNDING. Sponsor(s) authorize any third party funding, i.e. insurance or funding source, to be paid directly to RHR.

______________________________  ________________________________
(Signature)                        (Signature)

State of ______________________  )
                           )
County of______________________ )

On _____ day of __________, year ______, before me ____________________________, Notary Public in and for said county, personally appeared before me, ____________________________________________, who has / have satisfactorily identified him / her / themselves as the signer(s) or witness(es) to the above reference document.

______________________________
(Signature of Notary)

______________________________
(Date)                        My commission expires
Power of Attorney and Waiver

I/We hereby grant to Renewed Hope Ranch, L.L.C. (“RHR”), full informed consent, authority and permission to provide such care, treatment, and evaluation, to the minor child _______________________, Date of Birth _______________________, as RHR considers being necessary and appropriate, consistent with the needs of the patient. This shall include consent for securing urgent of emergency medical or dental treatment when, in the opinion of RHR, such treatment is appropriate. Authorization is given for pregnancy testing, drug screening and tuberculosis testing. RHR is authorized to provide for hospital care and to authorize a physician to perform any procedures that may be deem medically necessary for the well-being of the patient.

I/We further consent for RHR to release confidential medical and mental health information to those agents whose direct responsibility is to determine medical necessity and/or payment of claims. I/We understand that the records may contain diagnosis, treatment and prognosis with respect to physical and mental conditions, to include records of alcohol and drug abuse, and/or treatment.

I/We further give informed consent for the patient to participate in all programs and activities of RHR, including but not limited to educational or therapeutic programs, work projects, training programs, and various forms of recreation and athletics, except the following specified programs or activities. If no exceptions are indicated, Sponsor agrees that no exceptions exist.

Exceptions ______________________________________________________________________________________________

I/WE FURTHER AGREE TO RELEASE RHR, ITS EMPLOYEES AND ITS AGENTS FROM ALL LIABILITY FOR ANY INJURY TO THE PATIENT CAUSED BY ANY ACT OR OMISSION ON THEIR PART IN THE COURSE OF SUCH FIELD TRIPS, ACTIVITIES, AND LEAVES; AND TO INDEMNIFY AND HOLD HARMLESS RHR, ITS MEDICAL STAFF, ITS EMPLOYEES AND ITS AGENTS FROM ALL CLAIMS, COSTS AND LOSSES INCURRED AS A RESULT OF ANY ACT OF THE PATIENT WHILE ON SUCH FIELD TRIPS, ACTIVITIES AND LEAVES.

I/We consent to the taking of photographs and to videotaping for internal identification and therapeutic purposes. It is understood that, with the specific exception of identification of patients absent without leave, no likeness shall be disclosed externally without specific written authorization.

I/We understand that the use of reasonable restraint and/or confinement may be necessary, if severity of symptoms or behaviors warrant, in order to protect the patient from harming himself/herself or others, or destroying RHR property. Should such restraint and/or confinement become necessary during the patient’s admission, I/We understand and agree to indemnify RHR, its employees or agents from any loss due to injury that may occur as a result of such restraint and/or confinement.

I/We further agree to the search of the resident and personal effects of the resident at any time, and seize and confiscate any item deemed to be contraband or counterproductive to the resident’s successful treatment of the program.

This Power of Attorney shall be effective from the date of signature until the resident’s completion of the program unless sponsor terminates enrollment through early withdrawal of the resident form the program. In no case shall the term of this Power of Attorney exceed six (6) years from the date of signature, at which time it shall automatically terminate if not earlier terminated.

__________________________________________________________________________  ______________________________________________________________________
(Signature)                                                                 (Signature)

State of ___________________ )                                                                                       
County of ___________________ )                                                                                   

On ______ day of __________, year _______, before me ________________________________, Notary Public in and for said county, personally appeared before me, ________________________________, who has / have satisfactorily identified him / her / themselves as the signer(s) or witness(es) to the above reference document.

____________________________________                                     ________________________________
(Signature of Notary)                                                                                              

_________ ___________ ___________ My commission expires
(Date)
### INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN REQUEST

One form per child (Please Type)

#### TO:  

#### FROM:

---

**SECTION I – IDENTIFYING DATA**

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

<table>
<thead>
<tr>
<th>Social Security Number:</th>
<th>CWA Eligible</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sex:</th>
<th>Date of Birth:</th>
<th>Tide IV-E determination</th>
<th>Yes</th>
<th>No</th>
<th>Pending</th>
</tr>
</thead>
</table>

Name of Mother:

Name of Father:

---

**SECTION II – PLACEMENT INFORMATION**

Name of Person(s) or facility Child is to be placed with: Phone:

<table>
<thead>
<tr>
<th>Address:</th>
</tr>
</thead>
</table>

Type of Care Requested:

- Foster Family Home
- Residential Treatment Center
- Parent
- Group Home Care
- Institutional Care-Article VI, Parent
- Relative (Not Parent) relation:
- Child Caring Institution
- Adjudicated Delinquent
- Other:
- Foster Home Study
- Other Enclosures
- Sending Agency to Supervise
- Court Jurisdiction Only

Current Legal Status of Child:

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

---

**SECTION III – SERVICES REQUESTED**

Initial Report Requested (If applicable):

- Parent Home Study
- Relative Home Study
- Adoptive Home Study
- Foster Home Study

Supervisory Services Requested:

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

Supervisory Reports Requested:

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

---

**SECTION IV – ACTION BY RECEIVING STATE PURSUANT TO ARTICLE III(a) of ICPC**

Placement may be made

Placement shall not be made

---

**REMARKS:**

---

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

Regular text items are needed on day of admission
**asterisk** items are needed, but may be sent shortly after arrival
Bold items are optional

Admissions Paperwork
- Original Application
- Signed Placement Agreement
- Signed Tuition and Billing Information
- Tuition and Enrollment Fee
- Copy of Birth Certificate
- Signed Power of Attorney and Waiver, Equine Consent, Release and Waiver of Liability, and Statement of Custody

Medical
- 2 week medication supply
- List of medication & dosages
- Copy of Insurance Card
- Immunization Records
- Signed Consent for Treatment
- Signed Management of Prescription Medications

Other
- Letters of Encouragement

We suggest that you include a few letters of encouragement for your daughter from the immediate family. Focus on your love, support and faith in her; refrain from any reasoning, explanations or apologies for the decision of treatment.

Clothing List
- 5-8 pair of boot cut jeans or mid-rise or higher-cut jeans. (can be combination of pants, jeans and knee length shorts) Due to Ranch Activities:
  - 2 pairs of athletic shorts
  - 2 pairs of pajamas
  - 1 pair of athletic shoes
  - 1 pair of riding boots
  - 1 pair of sandals or slippers
  - 1 pair of flip-flops
  - 7 bras
  - 10 pairs of underwear (no thongs or g-strings)
  - 10 pairs of socks
  - **Bathing suit, modest, one piece
  - **Black and Whites – black dress pants or skirt, white blouse, dress shoes (for special outings, dinners, activities, performances, etc.)

*We encourage our residents to pursue interests and talents such as art, music, etc. After the resident demonstrates a level of trust, permission to send in items such as musical instruments, art supplies, etc. can be discussed and approved through our Residential Director.

*We understand the need for traveling light for admission and that it can be a challenge to bring ALL items at once. Please keep in mind that you can send packages ahead of time or shortly after your daughter arrives. If in doubt, give us a call! Don’t be compelled to purchase all of the optional items for admission. Save some items to send in during her first few weeks. She will appreciate receiving items in the mail from home.

Personal Items
- Water bottle – personal size, heavy duty type
- Photos (limited to family)
- Stuffed animal
- Journal
- Brush or Comb
- Stationery, Scrapbooking supplies
- Pens, pencils
- Books (of appropriate nature)
- Spiritual or Inspirational books
- Jewelry (no valuables)
- Hair bands
- Face Wash
- Hair styling products
- Electric shaver

All hygiene products must contain no or minimal alcohol content – no aerosols of any kind. Mouthwash must be alcohol-free.

Optional items
Renewed Hope Ranch supplies these items; the following personal items are optional
- Pillow
- Twin Size sheets, blanket
- Shampoo & Conditioner
- Lotion, lip balm
- Deodorant
- Toothbrush and toothpaste
- Feminine hygiene products
- Hair dryer

Items not permitted at Renewed Hope Ranch
- Electronic devices
- Magazines
- Over the counter medications
- Gum, candy, snacks
- Glass items
- Razors
- Hygiene items containing alcohol

Our Mailing Address:
Renewed Hope Ranch
Attn: Steve Barrick
425 East 6000 North
Enoch, UT 84721

Resident Email (put resident’s name in subject line):
residentmail@renewedhoperanch.com
Tuition and Billing Information

The first 30 days tuition and enrolment fees are due upon admission. Tuition statements thereafter are sent out monthly, with payment due within 30 days from the date of mailing. An 18% late fee is assessed to tuition not received within 30 days. If billing reaches 30 days without payment, a 7-day Notice of Enrollment Termination may be issued by RHR to the Sponsor. Thirty days written notice is required from the Sponsor to RHR for early termination of treatment as covered in the Placement Agreement. If thirty days notice is not received, Sponsor is billed for 30 days from date of unscheduled discharge. Collection costs incurred by RHR are the responsibility of the Sponsor. Billing questions should be directed to Accounting at __________ ext. __________ or accounting@renewedhoperanch.com.

Costs not included in Tuition
Costs not covered by tuition include medication and psychiatric visits, which will be billed to your insurance. Other costs you can expect are: travel to and from RHR for admission and completion of treatment, travel for home visits, travel and lodging for parent visits and Family Weekends, co-pays for medical, dental, and medications, and spending account for incidentals that your child may request or require during treatment. We recommend a pre-paid Visa or similar spending card that you can manage and track account balances and spending.

Insurance and Billing
As a courtesy, RHR will help you to navigate through the insurance process. Approval of insurance benefits is not a guarantee of payment. Actual funds received are applied to the current billing cycle and reflected on the tuition statement: billing is not adjusted for anticipated insurance payments.

☐ I / We request and consent to billing our insurance for eligible services provided at RHR.
☐ I / We decline to pursue insurance benefits in association with treatment expenses at RHR. I / We also agree that once this waiver has been declared it will not be rescinded. Credit Card information must be provided to cover medical, pharmacy, and dental charges.

Costs Due upon Admission
A credit card must be kept on file for charges not covered by insurance for routine or emergency medical, pharmacy or dental charges and / or co-pays due at time of service or incidental costs associated with your child’s treatment. I / We request and give consent to RHR to charge the credit card listed below for the following fees and services. Recurring payment for services will only be made if indicated. Fees will be approved by cardholder prior to billing.

Resident __________________________________________________________
Address __________________________________________________________
City, State, Zip ____________________________________________________
Phone ____________________________________________________________

☐ Enrollment fee Amount $___________ ☐ One time
☐ Tuition Amount $___________ ☐ One time ☐ Bill monthly
☐ Medical & Dental Charges As required
☐ Pharmacy As required

Credit Card

Cardholder name __________________________________ Card number __________________________
Cardholder address __________________________________ Expiration date _______________________
City, State, Zip __________________________________ CVV code ____________________________

(Parent Signature) ____________________________________________ (Date) ______________________
Consent for Treatment

The following applies to routine or emergency medical or dental services. I understand that I will be consulted by telephone beforehand, if possible, and that I will be kept apprised of all medical needs.

_______ I hereby give Renewed Hope Ranch, LLC permission, after careful medical examination, to authorize any emergency treatment, surgery, or examination indicated for the benefit of the health of the above named child.

_______ I hereby give permission for routine dental cleaning, fluoride and x-rays and I assume responsibility for such charges.

_______ I authorize the release of any medical information regarding the above named resident to Renewed Hope Ranch LLC. Any medical, mental health or dental practitioner is hereby authorized to release all information regarding such treatment or history of this patient to Renewed Hope Ranch, LLC.

_______ I acknowledge that I am ultimately responsible for the payment of any medical services. The provider will bill the Sponsor directly.

_______ When insurance information is indicated below, provider will automatically submit charges for insurance payment, Co-pays, deductibles, and balances after insurance payments will be billed to me directly or charged to the credit card indicated below.

_______ If no insurance information is indicated, the provider will bill me directly or charge the credit card indicated below.

____________________________  ____________________________  __________________
(Parent Signature)  (Parent Signature)  (Representative of RHR)

Insurance Information
Resident Name ___________________________ Date of Birth ___________________________
Name of Insured ___________________________ Date of Birth ___________________________
Insured's Street address ___________________________ Insured's home phone: ___________________________
City, St., Zip ___________________________ Insured's cell number: ___________________________
Employer ___________________________
Name of Provider ___________________________ Mental Health Coverage ___________________________
Policies or Plan # ___________________________ Medical Coverage ___________________________
Group number ___________________________ Prescription Coverage ___________________________

Pharmacy
The undersigned Parent / Guardian hereby represents that their child is covered by the above insurance policy and requests that ___________________________ Pharmacy will bill said insurance for medications prescribed. Parent / guardian will pay all applicable co-pays or amounts not covered by insurance policy. ___________________________ Pharmacy can hold credit card information or send monthly statements. Parent / Guardian also acknowledge receipt of the HIPPA policy for ___________________________ Pharmacy.

Drug Allergies ________________________________________
Current Medications ______________________________________

Credit Card # ___________________________ Expiration Date: ___________________________

____________________________  ____________________________  __________________
(Parent Signature)  (Parent Signature)  (Representative of RHR)
Management of Prescription Medications

The following applies to prescriptions for medical and/or psychiatric medications. I understand that I will be consulted by telephone beforehand and that I will be kept apprised of all medical needs. I understand the options, risks, payment differences, and needs related to my options to have prescriptions filled while at Renewed Hope Ranch.

Please initial the option that best meets your needs:

__________ Pharmacy, is a community based pharmacy near Renewed Hope Ranch. Your identified insurance policy will be billed for medications prescribed. Parent / guardian will pay all applicable co-pays or amounts not covered by insurance policy. Pharmacy can hold credit card information or send monthly statements. Parent / Guardian also acknowledge receipt of the HIPPA policy for Pharmacy.

__________ Home Pharmacy, is your identified preferred home pharmacy. Your identified insurance policy will be billed for all medications through your identified home pharmacy. Prescriptions will be called into your identified home pharmacy. Filling, picking up, and sending prescriptions will be worked out by the parent/guardian and the home pharmacy. Two options are typical: (1) parent fills the prescription and picks it up and mails the prescription or (2) parent fills the prescription at the home pharmacy and the pharmacy mails the prescription.

(initial) **________ I acknowledge that I am ultimately responsible to insure that the prescriptions are filled and sent timely and when needed overnight express to Renewed Hope Ranch to insure continuation of medication.

Special Circumstances

__________ I understand that all prescribed antibiotics will be filled at Pharmacy to insure that medical treatment starts without delay. I acknowledge responsibility to pay all applicable co-pays or amounts not covered by my insurance policy.

__________ At the time of my daughter’s admission, I acknowledge that it is my responsibility to provide 14 days of current prescribed medications for my daughter.

__________ While my daughter is enrolled at Renewed Hope Ranch, I understand to insure quality of care that when a new psychotropic medication is started after admission I have chosen one of the two options: (1) If I choose Pharmacy as the primary pharmacy, the prescription will be filled and billed there and (2) if I choose the home pharmacy as the primary pharmacy, Renewed Hope Ranch will fill and bill the first 7 day supply at Pharmacy and the 30+ day supply will be filled and mailed through your home pharmacy.

(Parent Signature) (Parent Signature) (Representative of Renewed Hope Ranch)
Equine Consent, Release and Waiver of Liability

Equine Release and Waiver of Liability Assumption of Risk and Indemnity Agreement. **Read this agreement carefully before signing it, your signature indicates you understand it and agree to its terms. By signing this agreement, you and your child give up certain legal rights, including the right to sue or recover damages in case of injury, death of property damage, for any reason, including but not limited to, the negligence of the Renewed Hope Ranch facility, its owners, employees and agents.** Both parents or legal guardians please fill in the following:

Name of Resident ____________________________________________

Name of Parent(s) ____________________________________________

In consideration for allowing me, or my minor child, to engage in therapeutic activities and on occasion ride on and interact with a horse, and on behalf of myself, my child, or our personal representative, heirs, next of kin, spouses and assigns, I hereby;

- Acknowledge that caring for horses, horseback riding and all therapeutic activities involving horses entail known and unanticipated risks which could result in physical or emotional injury, paralysis, death, or damage to myself, my children, my parents or to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity. The risk includes, among other things; loss of control and collisions. Horses, irrespective of their previous behavior and characteristics, may act or react unpredictably based upon instinct, fright, or lack of proper control by the participant, latent or apparent defects or conditions in equipment, animals or property, of other participants in this activity, adverse weather conditions, contact with plants, insects or other animals or property; my own physical condition or my own acts or omissions. The instructors have difficult jobs to perform. They seek safety, but are not infallible. They might be unaware of a participant’s fitness or abilities. They might misjudge the weather or the elements surrounding them at that moment.

- I expressly agree and promise to accept and assume all of the risk existing in this activity. My participation in this activity is purely voluntary, and I elect to participate in spite of the risks.

- I hereby voluntarily release, forever discharge and agree in indemnity and hold harmless Renewed Hope Ranch from any and all claims, demands, or causes of actions, which are in any way connected with my participation in the activity or my use of the equipment or the facility, including any such claims which allege negligent acts or omissions of Renewed Hope Ranch.

- Should Renewed Hope Ranch, or anyone acting on their behalf, be required to incur attorney’s fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.

- I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating, or else I agree to bear the cost of such injury or damage myself. I further certify that I have no medical or physical conditions which could interfere with my safety in this activity, or else I am willing to assume, (bear the cost of) all risks that may be created, directly or indirectly, by any such condition.

- In the event that I file a lawsuit against Renewed Hope Ranch, I agree to do so solely in the state of Utah, and I further agree that the substantive law of the state of Utah shall apply in that action without regard to conflict of law rules of that state. I agree that if any portion of this Agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.

By signing this document, I acknowledge that if anyone is injured or property is damaged during my participation in this activity, I may be found by a court of law to have waived my right to maintain a lawsuit against Renewed Hope Ranch on the basis of any claim from which I have released them herein and it is my intent to release any right to assert a lawsuit or claim, and to waive any claim of liability against, Renewed Hope Ranch and its agents, employees, owners and representatives. I have had sufficient opportunity to read this entire document. I have read and understand it, and I agree to be bound by its terms.

_____________________________     _______  
(Parent Signature)              (Parent Signature)  (Representative of Renewed Hope Ranch)
As a participant in an equine-assistant event, I agree to the following:
I will respect our session space which includes the barn, the grounds, and the arena.
I will be respectful of the Equine Leaders, staff, horses, and property.
I will not run or act in a manner that may frighten the horses or cause distraction to other participants.
I will wear appropriate footwear.
I will dress appropriately for the activity and weather.
I will not bring any personal belongings into the equine arena.
I will not bring food or drink into the equine area.
I will inform Program Administration of my medical needs that are known or may arise during an equine activity.
I will not smoke on the premises of Renewed Hope Ranch. This includes the barn, arena and surrounding areas.

Name of Resident ___________________________ Signature ___________________________
Name of Participant ___________________________ Signature ___________________________
Name of Participant ___________________________ Signature ___________________________
Name of Participant ___________________________ Signature ___________________________
Name of Resident ____________________________
Resident lives with ____________________________________________

Parents marital status: ☐ Intact ☐ Separated ☐ Divorced

Legal Custody: ☐ N/A ☐ Joint/Shared ☐ Mother ☐ Father ☐ Guardian ☐ Other:

If custodial status is other than both parents in a married or intact relationship, a decree of divorce or legal separation indicating custody and visitation must be attached. If the custody has been granted to another party, legal documentation must be attached.

If no contact should be allowed with non-custodial parent(s), please list name(s) below and provide supporting documentation.

_____________________________________________________________________________________________

I affirm that as the ☐ Parent ☐ Guardian, I have legal custody of the above named minor and do hereby request and consent to the admission and treatment of said child to Renewed Hope Ranch.

_____________________________     _____________________________     _______

(Parent Signature) (Parent Signature) (Representative of Renewed Hope Ranch)

A psycho-education evaluation will be initiated upon signed consent. The evaluation is conducted by a multi-disciplinary professional team consisting of Masters’ Level clinicians, our Licensed Psychologist and evaluated and complied by our Psychiatrist to give a balanced and complete report. The finished report includes testing results, clinical interpretation, treatment recommendations and a DSM V diagnosis. The evaluation is used by our Treatment Team as a tool in determining an appropriate course of treatment. You may request a copy of testing results. Testing will not be conducted without this signed consent from the parent or guardian.

Cognitive
Tests in this area measure a student’s ability to remember what has been seen, heard and the ability to solve problems. They also reflect learning rate and assist in predicting how well a student will do in school. Tests such as: Woodcock Johnson – Revised: Part 1 or Wechsler Scales of Intelligence.

Academic
Tests in this area measure a student’s current reading, mathematics, and written expression and readiness skills. Tests such as Woodcock Johnson – Revised: Part 2, PACE Pre-Tests in math/language/reading, Kaufman Test of Educational Achievement, or Peabody Individual Achievement Test – Revised.

Social Emotional
Tests in this area assess a student’s personal independence and social functioning in home, school, and community. They also assess behavioral patterns that may adversely affect educational performances. Tests such as: Minnesota Multi-phasic Personality Inventory, Rorschach, Conner’s Rating Scale, Burk’s Behavior Scale, Sentence Completion, Achenbach, Bender Gestalt, Draw A Person, Personal History Inventory or Direct Observation.

Hearing / Vision
Tests in hearing assess sensitivity, visual screen acuity and processing abilities.

Vocational & Transition
Tests in this area are used to identify career strengths, limitations and interests. They also help to identify present functioning levels of life skills, habits and attitudes relating to vocational performance. Tests such as: Strong Interest Inventory.

Substance Abuse
Substance Abuse Subtle Screening Inventory. Other if Specified: ____________________________

_____________________________     _____________________________     ________________________

(Parent Signature) (Parent Signature) (Representative of Renewed Hope Ranch)
Explain symptoms before and after the accident on the injury information sheet that follows:

**INJURY INFORMATION SHEET – CONFIDENTIAL**

<table>
<thead>
<tr>
<th>Injured Party:</th>
<th>Date of accident:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Name:</td>
<td>Relationship:</td>
</tr>
<tr>
<td>Address:</td>
<td>City / Zip:</td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
</tbody>
</table>

**INSTRUCTIONS:** Fill out as completely as possible. Do not have the injured party help you. Do it yourself. Mark only items you have observed or heard complaints about. Where you have no knowledge, leave blank.

**COMPARE THE PROBLEMS OF THE INJURED PERSON BEFORE AND AFTER THE ACCIDENT.**

**BEFORE THE ACCIDENT**

**AFTER THE ACCIDENT**

### I. PHYSICAL

<table>
<thead>
<tr>
<th><strong>[MARK WITH “X”]</strong></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscle weakness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness and tingling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty sleeping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blurred vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ringing in ears</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lost or reduced taste or smell</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### II. COGNITIVE / MENTAL

<table>
<thead>
<tr>
<th><strong>[MARK WITH “X”]</strong></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concentration problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Memory problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduced reasoning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem solving skills impaired</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems doing math</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty following directions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty reading</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Word finding difficulty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doesn’t seem as smart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensitive to noise / confusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty expressing thoughts verbally</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### III. EMOTIONAL

<table>
<thead>
<tr>
<th></th>
<th>BEFORE THE ACCIDENT</th>
<th>AFTER THE ACCIDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Mark with “X”</td>
</tr>
<tr>
<td></td>
<td>Increased frustration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Decreased tolerance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Easily angered/short tempered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overreaction to events</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cries easily</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Irritable</td>
<td></td>
</tr>
</tbody>
</table>

### IV. PERSONALITY

<table>
<thead>
<tr>
<th></th>
<th>BEFORE THE ACCIDENT</th>
<th>AFTER THE ACCIDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Mark with “X”</td>
</tr>
<tr>
<td></td>
<td>Significant personality changes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Poor insight into problems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty following through with responsibilities at work or home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Apathy or loss of interest in hobbies, etc.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Problems getting going in the morning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Problems getting organized</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Problems with planning</td>
<td></td>
</tr>
</tbody>
</table>

### V. SOCIAL

<table>
<thead>
<tr>
<th></th>
<th>BEFORE THE ACCIDENT</th>
<th>AFTER THE ACCIDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Mark with “X”</td>
</tr>
<tr>
<td></td>
<td>Misunderstanding what is said by others</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Impulsive or inappropriate social behavior</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduced judgment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty getting along on the job or at school</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty establishing and maintaining relationships</td>
<td></td>
</tr>
</tbody>
</table>

### ADDITIONAL COMMENTS & EXPLANATIONS

[Use additional paper if necessary]

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
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