

NORTH DAKOTA APPLICATION FOR RESIDENTIAL SERVICES

DATE OF REFERRAL: **COMPLETED BY:**
(Signature)

NAME OF PERSON MAKING REFERRAL:

AGENCY NAME & ADDRESS:

TELEPHONE NUMBER:

FAX NUMBER:

CLIENT'S NAME: **DOB:** **AGE:**

PLACE OF BIRTH: **HEIGHT:** **WEIGHT:**

SSN: **GENDER:** **RACE:**

RELIGION:

CURRENT PLACEMENT OF CHILD:

ADDRESS & PHONE #:

MEDICAID ELIGIBLE: YES { } NO { } SSI ELIGIBLE: YES { } NO { }

MEDICAID (MA) #:

COUNTY ISSUING MA#:

THIRD PARTY INSURANCE COMPANY NAME, ADDRESS, PHONE NUMBER:

POLICY HOLDER'S NAME:

ADDRESS:

PHONE NUMBER:

LEGAL CUSTODY WITH:

PROBATION OFFICER:

COURT ORDER DATE:

PHONE NUMBER:

LEGAL CUSTODIAN NAME:

PHONE NUMBER:

FAX NUMBER:

ADDRESS:

COUNTY OF FINANCIAL RESPONSIBILITY:

ADDRESS:

CONTACT PERSON:

PHONE NUMBER:

BRIEF DESCRIPTION OF PRESENT TREATMENT ISSUES & CURRENT REASON FOR REFERRAL:

CURRENT ASSESSMENT OF RUNAWAY RISK, DANGER TO SELF AND OTHERS:

**BRIEF DESCRIPTION OF PRESENT THERAPY:
LOCATION:
NAME OF PROVIDER:**

**BRIEF DESCRIPTION OF FAMILY THERAPY:
LOCATION:
NAME OF PROVIDER:**

MOST RECENT DIAGNOSIS:

AXIS I:

AXIS II:

AXIS III:

AXIS IV:

AXIS V:

FAMILY ORIGIN:

FATHER'S NAME:

AGE:

ADDRESS:

PHONE #: (W)

(H)

LEVEL OF EDUCATION:

EMPLOYED: { } YES { } NO

OCCUPATION:

RACE:

BIRTH DATE:

RELIGION:

MOTHER'S NAME:

AGE:

ADDRESS:

PHONE #: (W)

(H)

LEVEL OF EDUCATION:

EMPLOYED: { } YES { } NO

OCCUPATION:

RACE:

BIRTH DATE:

RELIGION:

SIBLINGS:

NAME	SEX	AGE	ADDRESS	RELATIONSHIP
OTHER SIGNIFICANT PEOPLE IN CHILD'S LIFE				

DOES EITHER PARENT CURRENTLY HAVE A SIGNIFICANT OTHER LIVING WITH THEM? IF YES, PLEASE SPECIFY WHICH PARENT, AND IF THE SIGNIFICANT OTHER HAS CHILDREN LIVING WITH THEM IN THE HOME:

FAMILY HISTORY (Divorce, history of physical, verbal, emotional, or sexual abuse or neglect, domestic violence, family dynamics, etc.):

FOSTER CARE ENTRY AND DISCHARGE DATES (most current first):

ENTRY	DISCHARGE	PROVIDER NAME/ADDRESS	TYPE

**IF THE CHILD IS NOT PRESENTLY PLACED IN THE BIOLOGICAL HOME,
PLEASE COMPLETE:**

NUMBER OF CHILDREN IN CURRENT FOSTER HOME, IF APPLICABLE: _____

NAME	SEX	AGE	RELATIONSHIP TO FOSTER PARENT(S)

HISTORY OF CLIENT'S BEHAVIOR:

- 1. DESTRUCTIVENESS (include fire-setting):**
 - 2. AGGRESSIVENESS/SEXUAL OFFENDING:**
 - 3. SOCIAL STRENGTHS AND WEAKNESSES:**
 - 4. RELATIONSHIP WITH PEERS:**
 - 5. RELATIONSHIP WITH ADULTS:**
 - 6. RELATIONSHIP WITH AUTHORITY:**
 - 7. VIOLENCE TO SELF/SIB/PIERCING/TATTOOS:**
 - 8. VIOLENCE TO OTHERS (include animals):**
 - 9. EATING AND SLEEPING HABITS (eating and sleeping disorder symptoms):**
 - 10. SUICIDE ATTEMPTS/IDEATION (child):**
 - 11. MENTAL ILLNESS HISTORY (family):**
 - 12. HISTORY OF SEXUALITY (sexually active, STD's, pregnancy, etc.):**
 - 13. ALCOHOL AND DRUG USAGE, INCLUDING SMOKING, HUFFING (child) - Treatment?**
- Parental/Other Members - Treatment?**

Has client been assessed for Fetal Alcohol Syndrome/Fetal Alcohol Effects? { } Yes
() No

If yes, what were the results? _____

14. LEGAL HISTORY:

15. RUNAWAY HISTORY (Who he/she ran with? What does he/she do on run?):

16. THOUGHT DISORDER:

17. OTHER:

ABUSE/NEGLECT HISTORY:

VICTIM OF ABUSE

TYPE OF ABUSE	KNOWN PERPETRATOR (NAME)	WHEN AND HOW LONG	INVESTIGATED	SUBSTANTIATED

CURRENT CONTACT, IF ANY, WITH KNOWN PERPETRATORS(S):

CLIENT'S NAME:

PERPETRATOR OF ABUSE:

TYPE OF ABUSE	RELATIONSHIP OF VICTIM TO CLIENT	WHEN AND HOW LONG	INVESTIGATED	SUBSTANTIATED

MEDICAL HISTORY:

1. **KNOWN MEDICAL PROBLEMS/DISABILITIES/HEAD INJURIES**
(include allergies: meds, food, insects, etc.):
2. **MEDICATIONS** (current and past):
3. **PRENATAL, INFANCY, AND CHILDHOOD DEVELOPMENT:**
4. **ADOLESCENT DEVELOPMENT:**
5. **IMMUNIZATION RECORD:**

TYPE	DATE	TYPE	DATE

DOCTOR'S NAME	CLINIC/ADDRESS	PHONE #	LAST EXAM
DENTIST:			
OPTOMETRIST:			
FAMILY DOCTOR:			
PSYCHOLOGIST:			

EDUCATION:

HOME SCHOOL DISTRICT:
SUPERINTENDENT'S NAME:
ADDRESS/PHONE #:

PRESENT GRADE LEVEL: LAST GRADE COMPLETED: ED: GED:
GED COMPLETED: GED WAIVER: FULL SCALE IQ:
PERFORMANCE IQ: VERBAL IQ: ED: LD:

EDUCATIONAL DEVELOPMENT (History of learning or perceptual problems, sensory handicaps, dyslexia, etc.):

RECEIVING SPECIAL EDUCATION? WHAT NEEDS?

SPECIAL EDUCATION DISTRICT:

ADDRESS/PHONE #:

TRUANCY:

PEER RELATIONSHIPS (in school):

RELATIONSHIP WITH TEACHERS/COUNSELORS:

PAST YEAR AND PRESENT YEAR PERFORMANCE (average grades):

INDEPENDENT LIVING SKILLS CURRICULUM:

HAS SCHOOL BEEN INFORMED OF REFERRAL?

CURRENT ED IEP DATE:

CHILD'S INTEREST/SKILLS IN AREA OF VOCATION/WORK:

SCHOOL PLACEMENT HISTORY:

SCHOOL NAME/ADDRESS	DATE ATTENDED

PAST PLACEMENTS (hospitalizations, group home, out-patient services, etc.) OR

FOSTER CARE:

AGENCY NAME/ ADDRESS	DATE OF PLACEMENT	REASON FOR PLACEMENT	DATE OF DISCHARGE

**HOME ON THE RANGE
CONTRACT FOR SERVICES**

A. Service To Be Provided By - (Contractor):

Home On The Range
16531 I-94
Sentinel Butte, ND 58654

B. At The Request Of - (Referral Source):

Referring Agency:
Address:
City/State/Zip:
Agency Representative:

C. Service To Be Provided To - (Client):

Youth's Name:
Date Of Birth:
Medical Assistance #:
Private Insurance Co.:
Policy #: Group#:
Policy Holder's Name:

D. Services To Be Provided:

Therapeutic Residential Child Care - all applicable services and care

E. Payment Plan / Procedure:

Fee Schedule - all fees are established by the licensing body of the facility (ND Dept. of Human Services) and are subject to change. **Consult current ND Dept. of Human Services manual letter defining applicable rates, or contact Home On The Range admissions office.** Billing for services is based on units of service, with one unit equaling one calendar day of actual care. Statements are provided monthly to the agency listed as the financially responsible agency.

*** Note - this fee does not include educational costs.** All applicable educational tuition, etc. is billed by the public school providing service directly to the agency of financial responsibility.

** All placement payments are payable to :

Home On The Range
16351 I-94
Sentinel Butte, ND 58654

F. Financial Responsibility:

Agency:
Address:
City/State/Zip:

G. Method For Resolution Of Dispute or Termination:

This contract may be terminated by either party by providing reasonable notice of the dissolution of these terms. The CONTRACTOR may terminate service based on the CLIENT's failure to cooperate with provided services and/or the stated expectations of the placement. The REFERRAL SOURCE, upon finding that the CONTRACTOR is not in compliance with any law or regulation, or applicable licensure and certification requirement, may terminate this contract upon written notice to the CONTRACTOR. Upon the termination or expiration of this contract, the CONTRACTOR shall cooperate in the orderly transition of client service and records and will grant, upon receipt of a signed release of information, copies of all requested client records generated by the CONTRACTOR.

H. Statement Of Confidentiality:

The REFERRAL SOURCE and the CONTRACTOR agree to comply with all client confidentiality requirements of the CONTRACTOR as well as state and federal law requirements.

I. Signature Block:

REFERRAL SOURCE:

Referring Agency

Date

CONTRACTOR:

Executive Director
Home On The Range

Date

HOME ON THE RANGE PLACEMENT AGREEMENT

Name of Child: _____
(Print or Type)

Youngsters who are referred to Home On The Range (hereinafter referred to as HOTR) for placement are those having difficulty in their home, school and/or community. Any youth who is referred will be considered for placement at HOTR. The goal of HOTR is to offer youth a program of service and care to meet their individual needs. If a youth is accepted, efforts will be made to help the child learn social, academic, self-maintenance and similar skills to aid him/her in a better adjustment to family, teachers, peers and members of the community. Efforts are made to return the resident to a community placement as soon as possible. Exact plans depend on the child's needs and family situation.

I have decided that the problems of my child are serious enough to warrant placement at HOTR. I understand my child will be considered for residence in the HOTR program. With this understanding, I agree to the condition of this consent form, as indicated.

I understand that I am not, nor will be, deprived of my parental rights. However I agree to extend these parental rights to the staff at HOTR. This includes signing official documents, school permission forms, medical forms, etc.

I understand at the discretion of HOTR personnel, in accordance with the treatment plan, that my child will be able to spend holidays and vacation time with me. I agree to accept responsibility for my child during such periods and will notify the staff of HOTR immediately if any evidence of difficulty should appear. For example, if my youngster runs away or becomes physically abusive or is arrested, I would agree to contact the HOTR staff immediately to inform them of such happenings. I agree to return the child "on time" in accordance with plans made with HOTR staff.

I give my permission to the staff of HOTR to use physical restraint in the event that it is necessary to protect the health or safety of him/herself or others. It is understood that physical restraint in this context means holding the arms or legs of the child to prevent damage to oneself and/or other people. I understand the Ranch has a policy of never physically abusing (hitting, spanking, kicking, etc.) a child for discipline or punishment.

I understand the HOTR provides an "All Faiths" chapel service for all youth. I also understand that youngsters other than Christian youth are never excluded from the HOTR program because of their religious preferences and that special arrangements will be made for those youth to attend community services in accordance with their personal belief. I am aware that, regardless of my child's religious preference, my child, as well as all other HOTR residents, are expected to attend a religious service each week unless they have a legitimate reason for not attending.

I understand that the HOTR program includes physical activities such as football, basketball, soccer and similar vigorous activities. Unless my child has some physical limitations that make it medically unwise to participate if he/she so desires, I authorize such participation. I also will allow him/her to travel with teams and similar groups for such participation.

I understand that HOTR is a working ranch and that it operates a farm/ranch and vocational program. I understand that while my child is at HOTR he/she may at one time or another operate machinery, equipment or vehicles as part of his/her work experience, which is a part of the HOTR program. I understand that he/she will be given proper instruction in both the use of machinery and safety procedures associated with their use and that he/she will not be allowed to operate such equipment until he/she has demonstrated competency in the operation of such equipment and machinery.

Thus, in general, I agree to the cooperative relinquishment of the control and management of my child to engage in any activity that the staff deems appropriate for my child's benefit.

I understand that, given the problems of my child, placement at HOTR is the least restrictive alternative placement.

Parent: _____

Parent: _____

Resident: _____

Referring Agency Representative: _____ Date: _____

HOME ON THE RANGE
AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, hereby freely and voluntarily authorize

Name of Person/Hospital/Agency Address City/State/Zip

to release the following information concerning _____

Name of Client Date of Birth

to _____
Name of Person/Hospital/Agency Address City/State/Zip

Information to be released:

This information is necessary for (circle): Diagnosis and Treatment / Follow-Up

Other: (specify) _____

I understand that I do not have to give this authorization to receive treatment services and that I may revoke this authorization to release information at any time by giving written notice to Home On The Range. However, I also understand that any information released prior to my revoking this authorization shall not be a breach of my Right of Confidentiality. Unless I revoke this authorization prior to such time, this authorization shall expire _____ days from the date of the authorizing signature below.

Client Signature Date Witness Date

If the client is a minor (under the age of 18 in the state of North Dakota) or has a legal guardian appointed by the court, this authorization to release information must be signed by the client's responsible parent or legal guardian and must be signed by the client if the client is over age 12.

Parent/Guardian Signature Date Witness Date

Relationship to Client

__ CHECK IF APPLICABLE - NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS: This information has been disclosed to you from records, the confidentiality of which is protected by federal law. Federal regulations (42CRF Part 2) prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

**HOME ON THE RANGE
DOCUMENTATION OF COMMUNITY / FAMILY SERVICES**

Licensing guidelines for group and residential care facilities in North Dakota, specifically Section 75-03-16-16, #4 states:

- "e. The facility shall request documentation of the services the parents or custodian will receive in the home community while the child is receiving services in the facility.**
- f. The facility shall request quarterly progress reports from the agency providing services to the parents or custodians."**

Below is a simple form for your convenience with which to document family services. Please complete and return as soon as possible.

Youth's Name: _____ Date: _____
Parent/Guardian Name: _____
Referring Agency: _____
Referring Case Manager: _____

Community Service Provider: _____
Address: _____
Agency Contact: _____ Telephone: _____

Brief description of services provided:

Comments:

Referring Case Manager

Date

HOME ON THE RANGE

MEDICAL RELEASE

TO WHOM IT MAY CONCERN:

I, _____, parent/guardian of _____
(Child's Name)
for the mutual conditions of covenant and terms herein do hereby grant permission to Home On The
Range (hereinafter referred to as HOTR) and/or its administrative authorities to provide any medical
care it deems necessary for the well-being of _____.
(Child's Name)

FURTHER, should _____ develop any illness or sustain an
(Child's Name)
emergency injury requiring immediate medical care and/or hospitalization, in the judgment of HOTR
and/or its administrative authorities, permission is herewith granted by me _____
(Parent/Guardian)
for any necessary medical care.

I (we) further consent to:

- 1. All medical tests and immunizations deemed advisable by HOTR's medical advisors and/or consultants.
- 2. All medical and dental care deemed necessary by HOTR's medical advisors and/or consultants.
- 3. The usage of anesthesia and/or furnishing any surgical treatment by the medical advisors and/or consultants of HOTR, if in the opinion of said advisors and/or consultants such an emergency exists or may unexpectedly arise. In keeping with the concept of the importance of parental and agency awareness, every effort will be made by HOTR to secure such surgical releases when in the opinion of said advisors and/or consultants no emergency exists or may unexpectedly arise.
- 4. To sign all medical forms deemed necessary to obtain medical attention. These forms include but are not limited to medical treatment forms, procedural consent forms, financial responsibility, HIPAA, health insurance forms, or mental health forms.

Further, in consideration of the aforesaid payment and the added consideration of medical care granted by HOTR, its administrative authorities and/or its medical advisors or consultants, I hereby covenant that I will forever refrain for any reason from instituting, or in any way pressing any claim of any kind against HOTR, Sentinel Butte, ND, its administrative authorities and/or its medical advisors or consultants.

Furthermore, I hereby expressly stipulate and agree in consideration of the aforesaid payment in the event any claim is pressed by, or on behalf of, said minor, the undersigned will forever "stand in the shoes" and hold forever harmless HOTR, its administrative authorities and/or its medical advisors or consultants.

Parent/Guardian

Date

Referring Agency Rep.

Date

HOME ON THE RANGE
Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Home On The Range may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Home On The Range's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Home On The Range reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to HOTR Privacy Officer at 16351 I94, Sentinel Butte, ND 58654.

With my consent, Home On The Range may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as messages, permission slips, insurance items, and any call pertaining to my clinical care, including laboratory results, among others.

With my consent, Home On The Range may mail to my home or other designated location any items that assist in carrying out TPO, such as progress reports, permission slips, and patient statements, as long as they are marked Personal and Confidential.

With my consent, Home On The Range may email to my home or other designated location any items that assist the practice in carrying out TPO, such as progress reports, permission slips, and patient statements. I have the right to request that Home On The Range restrict how it uses or discloses my PHI to carry out TPO. However, the facility is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Home On The Range, use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing to the extent that the facility has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Home On The Range may decline to provide treatment to me.

Patient's Name

Signature of Patient or Legal Guardian

Date

Printed Name of Patient or Legal Guardian

HOTR Church Preference Form

Resident's Name: _____

It is the belief of HOTR that healing is aided when we address physical, psychological, social, and spiritual needs. Our founder, Fr. Elwood Cassedy, maintained that the key element of healthy human living is a moral/spiritual component. Thus our program offers this spiritual element. HOTR accepts children of all denominations as well as children that are non-denominational. No particular religion is ever imposed on anyone, but information about religion and spirituality is shared with all under our care. As the parent/guardian, please mark your preference for:

A) Select one:

I choose the designated community church for my child.

_____ Catholic

_____ Evangelical

_____ Lutheran

_____ My child may choose for himself/herself which of these three to attend.

B) Select one:

_____ I require that I be contacted to grant permission for my child to change churches.

OR

_____ I authorize my child to change churches without my approval.

C) Select one:

_____ I desire that my child attend church.

OR

_____ My child has my permission to decide for himself/herself if they want to attend church.

OR

_____ My child has my permission to NOT attend any religious activities. Required attendance at Moral Development group is therefore understood.

D) Add your comments:

SIGN AND DATE:

Parent/Guardian Signature

Date

HOTR Emergency Evacuation Plan

Resident in care: _____

Facility Location: 16351 I 94, Sentinel Butte, ND 58654 Ph.: 701-872-3745
Ph.: 701-872-3745 Cell #: 701-872-6396 (executive director)

In the event of an **emergency evacuation** of the facility, Home On The Range will use the following locations **within the same community:**

First Option:

St. John’s Catholic Church
142 2nd Ave N
Beach, ND 58621 Ph.: 701-872-4153

Second Option:

Beach High School
600 N Central Ave
Beach, ND 58621 Ph.: 701-872-4161

In the event we would need to relocate **outside the region:**

First option:

St. Patrick’s Church
310 2nd St. W
Dickinson, ND 58601 Ph.: 701-483-6700

Second option:

St. Bernard’s Church
404 3rd Ave NE
Belfield, ND 58622 Ph.: 701-575-4295

These locations will be utilized until a full assessment of the emergency is made and housing needs determined.

Please furnish contact information for the person(s) in which HOTR needs to contact in case of an emergency. Please provide work, home, and cell phone numbers. (Note: The phone numbers will <u>only</u> be contacted in a <u>real emergency</u> and will be kept confidential).	
Name: _____	Name: _____
Work #: _____	Work #: _____
Home #: _____	Home #: _____
Cell #: _____	Cell #: _____

HOTR understands that there are critical items we are urged to take with the resident when we evacuate. These may include:

- A copy of this form for each resident.
- Resident’s information (e.g. prescriptions, recent medical reports, physicians name and contact information, immunization history.)

HOTR understands that in the event that we must evacuate the facility, we are required to report each resident’s location to their legal custodian, licensing agent or the NDDHS. HOTR requests that if any of the information included in this plan changes, we be updated by the legal custodian within 14 days of the change.

Legal Custodian Signature: _____ Date: _____
Print Name: _____ Work Phone: _____
Home Phone: _____ Cell Phone: _____

Copies: ____ Legal Custodian ____ HOTR On-call Book

NDSU **North Dakota State University Home on the Range**
Department of Animal Sciences 16351 I-94
1300 Albrecht Boulevard Sentinel Butte, ND 58654
NDSU Dept. 7630 701.872.3745
PO Box 6050
Fargo, ND 58108-6050
701.231.9611

Title of Research Study: The effects of animal-assisted therapy on youth at-risk

This study is being conducted by: Mike Gooch at Home on the Range, e-mail mikeg@hotrnd.com, phone 701-872-3745 in conjunction with Erika Berg, from the Department of Animal Sciences at North Dakota State University.

Why is my child/legal ward being asked to take part in this research study? Individuals asked to participate in this study are residents at Home on the Range and have been identified as someone who would be a good candidate for equine or canine therapy by their peers, legal guardian, HOTR staff or by the individual themselves.

What is the reason for doing the study? The reason for doing this study is to examine the effects of equine or canine facilitated therapy on behaviors of youth considered 'at-risk.'

What will my child/legal ward be asked to do? Information that will be collected includes before and after self-reports (four instruments) as well as one parent report form that will be completed by the direct care staff at HOTR.

Timeline:

1. Complete self-reports before participating in equine or canine therapy
2. Participate in equine or canine therapy
3. Complete self-reports after participating in equine or canine therapy

Where is the study going to take place, and how long will it take? The study will take place at Home on the Range. It will take approximately 2 hours to complete the self-reports before and after completing the equine or canine therapy program. The equine therapy program itself ranges from 9 to 12 hours each week (weather and travel dependent in the winter months) from the time of entrance into the equine therapy program until discharge. The canine therapy program ranges from 6 to 9 hours each week from the time of entrance into the canine program until discharge.

What are the risks and discomforts? It is not possible to identify all potential risks in research procedures, but the researchers have taken reasonable safeguards to minimize any known risks to the participant. Potential risks include injury from the horse such as a kick or falling off when riding. Potential risks

include injury from the dog such as a bite. The animals used for this type of therapy are trained for it so the risk is very minimal. Emotional or psychological discomfort may arise as part of the therapy process. Licensed social workers who are certified in CPR and first aid and who have extensive training and experience in equine facilitated psychotherapy will be leading the sessions.

What are the benefits to me? Potential benefits may include reduced aggression and rule-breaking behaviors, as well as enhanced empathy and self-esteem. However, you may not get any benefit from being in this research study.

What are the benefits to other people? Knowledge gained from this research may help to develop programs that would benefit other youth in similar situations.

Does my child/legal ward have to take part in the study? Your child/legal ward's participation is voluntary and he/she can quit at any time. Your decision whether or not to allow your child/legal ward to participate will not affect you or your child/legal ward's treatment or present or future relationship with NDSU or Home on the Range or any other benefits to which they are otherwise entitled. If you decide to allow your child/legal ward to participate, you are free to withdraw your permission and to discontinue their participation at any time.

What are the alternatives to being in this research study? Your child/legal ward may choose to take part in the equine program without allowing their information to be used for the research.

Who will see my child/legal ward's information? We will keep private all research records that identify your child/legal ward. His/her information will be combined with information from other people taking part in the study. When we write about the study, we will write about the combined information that we have gathered. We may publish the results of the study; however, we will keep your child/legal ward's name and other identifying information private.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. For example, your child/legal ward's name will be separated from the research records before sharing the information for data analysis. You should know, however, that there are some circumstances in which we may have to show your child/legal ward's information to other people. For example the law may require us to show his/her information to a court or to tell authorities if we believe there has been child abuse or neglect, or if he/she poses a danger to his/herself or someone else.

What happens if I am injured because of this research? If your child/legal ward is injured in the course of taking part in the equine therapy, you should contact Mike Gooch at the following phone number 701-872-3745. Treatment for the injury will be available including first aid, emergency treatment and follow-up

care as needed. Payment for this treatment must be provided by you and your third party payer (such as health insurance or Medicare). This does not mean that you are releasing or waiving any legal right you might have against the researcher or NDSU as a result of your participation in this research.

What if I have questions?

You and your child/legal ward should feel free to ask questions now or at any time during the study. If you or your child/legal ward has questions about this study, you can contact Mike Gooch at mikeg@hotrnd.co or 701-872-3745.

What are my child/legal ward’s rights as a research participant?

Your child/legal ward has rights as a participant in research. If you have questions about these rights, or complaints about this research, you may talk to the researcher or contact the NDSU Human Research Protection Program by:

- Telephone: 701.231.8908
- Email: ndsu.irb@ndsu.edu
- Mail: NDSU HRPP Office, NDSU Dept. 4000, PO Box 6050, Fargo, ND 58108-6050.

The role of the Human Research Protection Program is to see that your rights are protected in this research; more information about your rights can be found at: www.ndsu.edu/research/irb .

Documentation of Informed Consent:

By signing this form, you are stating that you have read and understand this form and the research project, and are freely agreeing to allow your child/legal ward to be a part of this study. If there are things you do not understand about the study, please ask the researchers before you sign the form. You will be given a copy of this form to keep.

Parent/Guardian Signature	Printed Name	Date
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Parent/Guardian Signature	Printed Name	Date
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Relation to Participant	Name of Child/Legal Ward
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Researcher obtaining permission: Signature	Printed Name	Date
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