

Dear Parents/Guardians:

Thank you for your interest in Headway's Day Treatment Program in collaboration with Intermediate District 287. Our services are designed to meet the needs of youth in grades 7 through 12 who are experiencing mental health issues which make it difficult to be successful in a regular school setting. Headway provides treatment for a period of 9 to 12 months and works in conjunction with the District 287 to support youth in continuing their education.

In order to enroll your youth into our program, Headway will be gathering information from the enclosed paperwork. Please complete, sign and return the following:

- Day Treatment Application Determination Form
- All Releases (Releases of Information, ROI). This helps Headway gather information about past and present mental health symptoms, treatments, such as therapists, hospitalizations, residential and/or group home placements, or other day treatment programs, etc. Please complete a release for Intermediate District 287, which is the school district at both our Hopkins and Brooklyn Center locations that your youth becomes enrolled into when accepted to Headway Day Treatment. Also included is a release for your youth's current school, this allows Headway to gather information from the appropriate educational setting. Finally Headway enclosed releases for your youth's primary medical physician and psychiatrist/specific provider who is managing your youth's medications.
- Client Payment/Insurance Information. This should be completed with your youth's insurance
 information, including carrier/agency name and policy ID numbers. If your youth has more
 than one insurance, please list both policies. Send one completed copy to Headway and
 keep another for yourself. Headway encourages you to call your carrier and provide them
 with the H2012 code located on the form. This will allow them to check coverage specific to
 the Headway Day Treatment program.

Once Headway has received the Releases of Information signed by a parent/guardian, it can take up to **two weeks** to obtain the aforementioned information from all of the providers. **After Headway has received background information/records**, appropriate staff will be in contact with you to determine how to move forward with your referral.

Thank you for your attention to this important information. Please feel free to contact Headway's Administrative Assistant at 952-426-6600 (Hopkins) or 763-569-5200 (Brooklyn Center), then press "zero" to reach the front desk immediately.

Cordially,

Headway Day Treatment



Adolescent Day Treatment

WE CAN HELP

Headway Emotional Health Services helps individuals and families in the Twin Cities Metro area. We are committed to our mission of improving the lives of children and families and strengthening our communities through services and programs for everyone who needs them, regardless of life situation.

Headway Day Treatment provides an infrastructure that will help your child or adolescent succeed in their academic and personal life. We work with you and your child to help them achieve lasting results and skills.

WHO IS ELIGIBLE FOR DAY TREATMENT?



Services are for 7th-12th graders who have serious challenges in their mainstream academic settings because they are experiencing significant emotional and mental health issues.

WHEN?

Monday through Friday on a year-round basis consistent with District 287 school holidays.

FOR HOW LONG?

Treatment may range from 9 to 12 months during which there is ongoing assessment of the client's needs and progress.

A	vail	labl	le Y	ear	Rou	ınd
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

WHAT IS THE COST FOR DAY TREATMENT?

Day Treatment services may be covered by Private Insurance, Medical Assistance, TEFRA (Tax Equity and Fiscal Responsibility Act), and purchase of services contract with Hennepin County Children's Mental Health Collaborative.

Families may have a co-pay with their private insurance. Please call us for assistance in determining what options are available for you.



PROGRAM COMPONENTS

Curriculum is structured to enhance self-esteem, build social skills, and positive coping skills Group therapy addresses issues such as peer relationships, social and emotional learning, and behaviors which interfere with day-to-day life

Individual counseling occurs weekly to address treatment goals and progress



educational programming is coordinated with District 287 and the client's home school

Family therapy examines how family dynamics affect the client and how the client affects the family. Family members are expected to participate in sessions and to develop family treatment goals Adjunctive therapy incorporates interactive group activities such as art therapy, play therapy and relaxation techniques in the program design

PROGRAM STAFF

Headway Day Treatment staff have backgrounds in social work, counseling, as well as marriage and family therapy. The multidisciplinary team includes therapists, behavioral specialists, and mental health workers.

INTAKE PROCESS

Referrals may come from parents, schools, social service agencies, hospitals, and mental health treatment professionals.



To discuss a referral or learn more about our program, please call 952-426-6600 for the Hopkins location or 763-569-5200 for the Brooklyn Center location.



Headway Day Treatment

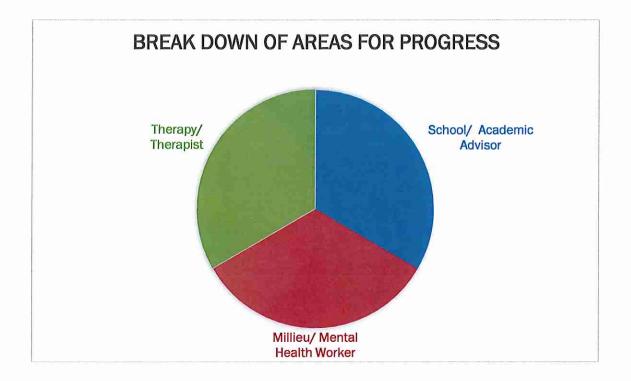
Eisenhower Community Center 1001 Highway 7, Suite 309 Hopkins, MN 55305 952-426-6600 Headway Day Treatment North 5910 Shingle Creek Parkway Brooklyn Center, MN 55430

763-569-5200

E-mail: daytreatment@headway.org headway.org

Headway Day Treatment: Areas of Potential Progress

The goal for each client is improvement in each of the three areas outlined below; Therapy, Milieu, School. Clients are not expected to obtain perfection in any area but instead show lasting improvement throughout their time at Headway.



Therapy: The therapy section is split into several subparts which include: individual therapy, group therapy, family therapy, and functioning at home and in the community.

Milieu: The milieu section is split into several subparts which include: skills groups, behaviors in the program, conflict resolution skills, utilization of breaks, participation, and attendance.

School: The school section is split into several subparts which include: classroom behaviors, grades, homework completion, and participation.

6 Core Strengths:

Attachment: "Making relationships." ... Being a friend.

Self-Regulation: "Containing Impulses." ... Think before you act.

Affiliation: "Being part of a group." ...Positively contributing to the milieu. Attunement: "Being aware of others." ... Thinking about others.

Tolerance: "Accepting differences." ... Not feeling threatened by new or different things. **Respect:** "Finding value in differences." ... Value yourself and others.

☐ Foster Parent



Day Treatment Application Determination Form

Client Information: Adolescent Name:______ Date of Birth:_____ Age: _____ Gender: Male Female Other: ____ Grade: ____ Ethnicity origin (or Race): Please specify your child's ethnicity. (Check all that apply) □Native American or American Indian □White □Asian / Pacific Islander ☐ Hispanic or Latino □Black or African American □Other: Name of person completing form:______ Relationship to adolescent:______ Who referred your adolescent?____ Please give a brief description of why you are seeking treatment for your adolescent: Family Information: Mother's Name:_____ Age:____ Education Level:____ Address: State:_____ Zip Code:_____ Home Phone:_____ Work Phone:_____ Cell Phone: _____ Email:_____ Relationship to adolescent: Natural Parent Step-Parent Adoptive Parent Foster Parent Adolescent primarily lives here □ *Marital Status: ______ Father's Name:_____ Age:____ Education Level:____ City:_____ State:____ Zip Code:_____ Home Phone:______ Work Phone:_____ Cell Phone:_____ Email:_____

Relationship to adolescent:

Natural Parent

Step-Parent

Adoptive Parent

*Marital Status:		Adolescent prim	arily lives here □			
*If divorced, a copy of the most recent Co	urt Documents	/Divorce Decree is m	andatory			
Family Information (Continued):						
Is the adolescent adopted? ☐ Yes ☐ No	If yes, specify	country of origin:				
Age when adolescent was first in h	ome:	Date of lega	l adoption:			
Adolescent currently lives with/for how long	g:					
If parent's are separated or divorce	ed, who has cu	stody of this adolesce	nt?:			
Dates of adolescent's parents' marriage, separation(s) and/or divorce:						
Comments about custody/visitation:						
Do any other adults live in the home?	∕es □ No					
If yes, please list Name/age/relation	onship to the a	dolescent:				
How many children are living in the home?	Pleas	e list Name/Age/Rela	tionship to the Adolescent:			
Name:	_ Age:	Relationship				
Name:	_ Age:	Relationship				
Name:	_ Age:	Relationship				
Name:	_ Age:	Relationship				
Name:	_ Age:	Relationship				
Name:	_ Age:	Relationship				
Abuse & Support Services History:						
Has your adolescent ever been abused?	□ Yes □ No					
If yes, please circle: Physically	Emotionally	Sexually	By ways of neglect			
Has your adolescent ever witnessed some	body else bein	g abused or hurt?				
If yes, please explain:			_			

What major stresses or change	s have occurred in your adol	escent's life?
Who does your adolescent regacoach, friends, pets, etc.)?	ard as the most supportive in	their life (specific family members, teacher,
List any involvement with socia	I services, child protection, t	he court system or legal services:
Developmental History:		
Pregnancy:		
Did the adolescent's mother re	ceive prenatal care during th	ne pregnancy?
☐ Yes, starting in which n	nonth?	
Mother's age during this pregn	ancy:	
Number of the following mothe	r has had:	
Pregnancies N	liscarriages Prem	nature Births
Were there any problems in pro	egnancy, labor, birth or delive	ery with this adolescent? ☐ Yes ☐ No
If yes, please give details:		
Did mother have any of the foll	owing during or immediately	before/after the pregnancy?
Maternal injury. Describe:_		
Hospitalization during preg	gnancy. Reason:	
X-rays during pregnancy. \	What month?	
Were any of the following used		
Tobacco Amphetamines Cocaine	Marijuana Heroin Alcohol	Methamphetamines Methadone Other (specify):

Development:

During the adolescent's first 3 years, were the	ere any special problems noted	in the following areas?
☐ Irritability ☐ Difficulty sleeping/feeding ☐ Failure to thrive/very poor weight gain ☐ Convulsions/twitching/seizures ☐ Unable to separate from parent	 □ Breathing problems □ Temper tantrums □ Excessive crying □ Early learning problems □ Other 	□ Colic□ Poor eye contact□ Withdrawn behavior□ Destructive behavior
Medical History/Previous Mental Health Treat	ment:	
Primary Care Clinic	Physician:	4
Do we have your permission to contact your a your adolescent's care: ☐ Yes ☐ No	dolescent's primary care physic	cian to assist with coordination of
Date of last medical examination:		
List any current medical problems:		
List any hospitalizations or serious medical pr	oblems:	
List any medications currently taking:		
List any previous medications taken and their	effectiveness:	
List any drug allergies:		
List any other allergies:		
Does your adolescent use any over-the-counter	er medications regularly/freque	ently?
Does your adolescent have any communicable	e diseases? ☐ Yes ☐	No
If yes, please list:	23.70	
Describe any family history of mental health of		ms or treatment:
List any counselors your adolescent has seen	n in the past and reason(s) for v	

ist dates of any psychiatric hospitalizations:				
Date of last appointment with Psychiatrist or Psych	nologist:			
Chemical Use History				
	No. 1 days	la - h - l · · ·		
lease check any that apply to your adolescent's n	on-prescribed aru	g or alconol u	sage.	
Drug Name	Use Currently	Within last 12 months	Have used in the past	Never
Cannabis - Marijuana, Hash				
Alcohol				
Amphetamines - Speed, Cocaine, Crack, Crank, Dexedrine, White Crosses, Ritalin, Cylert, etc.				
Tranquilizers - Valium, Xanax, Ativan, Librium, Sleeping Pills, Seconal, Quaaludes, etc.				
Narcotics - Codeine, Percodan, Darvon, Demerol, Morphine, Heroin, Methadone, Talwin, etc.				
Other - Inhalants, PCP, LSD, Mushrooms, Paint Thinner, Nitrite "Poppers", etc.				
as your adolescent used more than one chemical at the		er to get high?	☐ Yes ☐ No	
ooes your adolescent avoid family activities so he/she ooes your adolescent have a group of friends who also			☐ Yes ☐ N	
Does your adolescent use to improve his/her emotions eels sad or depressed?		ne	☐ Yes ☐ N	0
		le		
loes your adolescent use tobacco products?				
		Quantity per	day:	
Does your adolescent use caffeine?		If yes, type?		<u> </u>
		Quantity per	day:	

		Seve	rity	
Please list any concerns in the following areas, comment briefly, and rate them as indicated:	No Concerns	Mild	Moderate	Severe
Social Skills and interactions and relationships with peers:				
Social Skills and interactions and relationships with family members:				
Communication and language:				
Behavior and self-regulation:				
School work and learning:				
Emotional concerns:				
Self-esteem:				
Dietary/Nutrition:				
Medical (i.e. seizures, allergies, gastrointestinal or other):				
Other:				

Educational History:

Name of current school						
Has your adolescent ever repeated a grade?	□ Yes	□No	Reason			
If yes, what grade						
Does your adolescent like going to school?	□Yes	□No	Reason			
Has your child ever been suspended or expelled?	□Yes	□No	Reason			
Is your adolescent absent from school frequently?	□Yes	□No	Reason			
ls your child on an IEP (Individual Education Plan) or a 504 Plan?	□Yes	□ No				
If yes, for what reason?						
Special Classes/Services: Please check all that apply (specify what grade/frequency/duration)						
□ Specific Learning Disability (SLD)						
□ Emotional/Behavioral Disability (EBD)						
☐ Autism Spectrum Disorder (ASD)						
□ Speech/Language Impairment (SLI)						
□ Cognitive Disability (CD)			=			
□ Occupational Therapy (OT)						
☐ Physical Therapy (PT)						
☐ Adaptive Physical Education (APE)	·					
□ Other						

If your adolescent is in school please comment on the areas below:	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
Overall school performance					1
Reading					
Writing					
Mathematics					
Relationship with teachers					
Relationship with peers					

Other Helpful Information:
What are the strengths of your adolescent?
Does your adolescent have a Job or involved in extracurricular activities? If so, please list:
Is spirituality and/or faith system important to your family? To your adolescent?
Additional comments:
Date Application was completed:



Headway Financial Policy

Thank you for choosing Headway for your child and your family. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your family's treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment. All clients must complete our insurance form before your child/family can begin treatment (next page).

The costs of Day Treatment at Headway may be paid through:

- (1) A Purchase of Service Contract with Hennepin County.
- (2) Private Insurance and associated copayments.
- (3) In some cases, Medical Assistance/TEFRA.

Thus, in order for your child to attend Headway, we will be accessing your private insurance to cover day treatment, individual therapy and family therapy services. With most private insurance we will need to seek authorization for services and therefore may need various signatures from you during the course of treatment. In addition, there will most likely be a parental copay that is required when accessing your private insurance. We will make every effort to determine your copay in a timely manner and bill you accordingly for that amount.

Please be aware that if your private insurance does not cover day treatment and/or related therapy services, you may be responsible for full payment. Not all families have insurance that will cover therapy services. In these situations we suggest that you apply for TEFRA benefits. TEFRA, the Tax Equity and Fiscal Responsibility Act, is a type of assistance for families who have insurance benefits but need additional coverage for certain specific services for their child. TEFRA offers families more comprehensive coverage and/or benefits for a child. There will likely be a parental fee in these cases as well. Please call the number listed below if you would like assistance with a TEFRA application. Portico: 651-603-5122. www.porticohealthnet.org.

There is a portion of day treatment services, called case management, that Headway is contracted with Hennepin County to provide. We are required to seek authorization from the county for these services and again may ask you for your signature on various documents in seeking that authorization. Please ask a Headway staff person if you have questions regarding this process. It is important that you are aware that difficulty in accessing funds for services provided may result in a disruption or denial of day treatment services. Parents and legal guardians are financially responsible for their child's treatment. It remains our goal that no family be denied services because of a lack of ability to pay.

You may be responsible for a co-pay if it is required by your insurance policy. By law, Headway must bill for this co-pay. Co-pays are charged for each day of service provided to your child. Payment of co-pays can be made at any time. Headway's policy is to collect co-pays on a monthly basis. Payments received will be credited towards the earliest unpaid co-pays.

At the beginning of Headway staff will work with you to estimate what your co-pay will be, based on information provided by your insurance company. You may request to negotiate a payment plan with Headway so you pay a monthly amount that is comfortable for you. Headway would use "Schedule C," a sliding fee scale based upon your income, to determine this monthly amount. This may reduce the monthly amount owed but would increase the number of months over which you pay your balance. Schedule C is the fee schedule used by both Hennepin County and the State of Minnesota to determine appropriate co-payments with relation to income.

If you have a copay,

- > FULL PAYMENT IS DUE ON THE 18TH OF EACH MONTH.
- WE ACCEPT CASH, CHECKS, MONEY ORDERS, OR VISA & MASTERCARD.
- WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR APPROVAL OF THE OFFICE MANAGER/PROGRAM DIRECTOR.

By my signature below I am indicating that I have read the above financial policy and I agree to the terms. If for some reason I cannot adhere to these terms I will notify the office manager immediately. By my signature below I hereby authorize the release of all medical and psychological information to:

Write in primary insurance carrier	Write in secondary insurance carrier
as necessary to process claims for benefits, and I authorit	ze direct payment of benefits to Headway Emotional Health Services. or day treatment services I may be responsible for full payment.
understand that if my insurance company does not pay to	



Client Payment and Insurance Information:

Client's Name

		Address:
Insured's SSN:	DOB:	Patient's SSN:
Relationship to Patient:		Date of Birth:
Primary Insurance Company:		Secondary Insurance Company:
Address:		Address:
Phone Number:		Phone Number:
Policy Number:		Policy Number:
Group Number:		Group Number:
the fear the size about the same and		lical service. Parents/legal guardians are financially
responsible for their child's treatment. Date when benefits were checked:		ilical service. Farents/regar guardiane are illianolarly
responsible for their child's treatment. Date when benefits were checked: Effective Date:		ilical service. Farente, legal guardiane are illianistany
Date when benefits were checked:	2012: Is	it a covered service: □ Yes □No Yes, at what rate?
Date when benefits were checked: Effective Date:	2012: Is	it a covered service: □ Yes □No

Insured's Name:



Dear Parents/Guardians:

Headway and District 287 would like to thank everyone for your continued patience and collaboration as leadership teams diligently work to finalize the plan for in-person programming that kicks-off on Monday, September 28. We recognize this is a time of uncertainty and ambiguity for all and as we move forward the health and safety of all staff and students remain our top priority. Headway is adhering to the guidelines set by the Center of Disease and Control (CDC), the MN Department of Health, and school/county protocols. Headway and District 287 continue to collaborate as we make decisions to ensure the continuity of care for students and families.

On Monday, September 28th Day Treatment Programming will be returning IN-PERSON. Program hours are from 8AM to 2PM. Drop-off and pick-up takes place in front of the Eisenhower Community Building (Hopkins) or the Headway Academy Door 2 (Brooklyn Center). Headway Staff will be on location to conduct a verbal pre-screen of each student before they enter the building. Drop off is between 7:45 AM and 8:00 AM. Pick-up is at 2:00 PM

We are asking that all parents/guardians conduct a **Pre-Screen** of their student before sending them on transportation. If you child is showing any COVID-19 symptoms we ask that you keep your child home. Please refer to Pre-Screen Questions and COVID symptoms below:

Pre-Screen Health Questions:

- 1) Have you been in close contact with a confirmed case of COVID-19?
- 2) Are you experiencing a cough, shortness of breath, or sore threat?
- 3) Have you had a fever in the last 48 hours?
- 4) Have you had a new loss of taste or smell?
- 5) Have you had vomiting/diarrhea in the last 24 hours?
- 6) Are you currently waiting for results from a COVID-19 test?

COVID-19 Symptoms:

- Fever
- Chills
- Cough, shortness of breath
- Difficulty breathing
- · Fatigue, muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion
- Runny nose
- Nausea
- Vomiting
- Diarrhea

If you child arrives to programming reporting any of the symptoms mentioned above, they will be asked to return home on transportation, or a parent/guardian must immediately come to pick-up your student.

If your child is experiencing symptoms, and they are staying home, a parent/guardian must call the attendance line at 952-426-6613 (Hopkins) or 763-569-5202 (Brooklyn Center).

On Monday, September 28, Headway and District 287 staff will be making the following announcements to all students to ensure we are following "best practices" and following COVID-19 precautions and guidelines.

Students must follow COVID safety precautions and guidelines. Failure to do so will result in a call to parent/guardian.

- Masks must be worn at ALL TIMES! This policy will be enforced and Headway reserves the right to have student return home if they are incompliant with safety guidelines and policies
- · Students may remove masks while eating/drinking only
- Breakfast and Lunch will be delivered to each student in their community room
- Students are allowed to have a clear water bottle with them in the classroom and may remove their mask intermittently as needed
- Students are not allowed to share food, supplies or any fidgets, etc. with any other student
- Students are not allowed to leave the floor or the program area during program hours
- Students are not allowed to leave their classroom without staff permission
- Students are not allowed to bring backpacks to program. Lunch boxes or bags can be used and stored by student's locker or personal area within the classroom
- Student must ask for permission from staff to bring personal items such as; fidgets, calming tools, art supplies or non-school related items
- Students must remain 6 feet apart from other students and staff
- Students must stay to designated side of hallway when walking thru hallways
- Students should not move/roll around the room in rolling desks
- Students should not move stationary furniture
- Students and staff must utilize sanitizing stations outside of the classroom doors (before you enter and when you leave)
- Students and staff must wipe down/sanitize desks, workstations, and any supplies at the end of each use
- Students must turn all cells phones/electronic devices OFF and keep them stored in their personal bins or designated area (found in each community classroom or personal desk within the classroom)
- Students are excused to use the restrooms with permission from staff. Staff must radio when students are utilizing restrooms, only 2 students at a time
- Staff must radio "ALL CALL" when a student is dismissed to use the restroom and ALL call when the student returns
- Students must wait to be excused before taking breaks throughout the day. Staff must radio when student
 is asking for a break. Students must only take breaks in designated areas, as directed by staff
- Cleaning supplies must be kept in the designated areas of each classroom
- If student is feeling ill, student must ask to speak to staff immediately
- Students who are ill or showing symptoms will be placed in Quarantine Room and alternative transportation arrangements will be made once parent and/or guardians are notified
- Students and staff should limit use of Quarantine Room. Room cannot be accessed until 24 hours after student/staff with symptoms was isolated.

Therapy/Skills Groups and Academic Classes:

- Students will remain in their community rooms for Therapy Groups, Skills Groups, and Lunch
- Therapists will be moving to each community every 3 weeks to facilitate "Topics" Group to each community
- Students will remain in their community rooms for classes, teachers will be moving from classroom to classroom during academic hours
- Each community will receive their own school schedule
- Teachers have the right to give directives to students to keep their masks on at ALL TIMES, if student continues to not comply, please radio for MHW staff
- No snacks during class time. Those students who have medical conditions that require frequent snacking,
 you will be granted permission to eat snack in other room

Please keep in mind, this plan could change due to new/changing data, CDC or MN Department of Health guidelines, and/or MN Governor Directives.

Any student or family member in the home that is considered "high risk" for contracting COVID-19, you may "opt-out" of in-person programming beginning on September 28, 2020, however you must adhere to the following:

- A physician's note signed by a credentialed health care provider which must state for the health and safety
 of your child or family member it is advised they not resume in-person treatment/school. This letter must
 be submitted to your child's treatment team ASAP. *Headway does not require disclosure of specific
 medical diagnosis of student or family member.
- "High Risk" are considered to be people of any age with certain underlying/pre-existing medical conditions. For more information can be found at: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html
- Arrangements to receive telehealth/virtual programming will be made with your student's treatment team and approved by program administrative supervisor.

Transportation will be provided by your student's home school district or those insured by Medical Assistance (MA), you will set up an M.A. ride. It is imperative you contact your school district to arrange transportation to and from programming.

 When contacting your school district/transportation company, please give them the address and hours of programming: Drop off time: 7:45-8:00 AM and Pick up time: 2:00 PM.

> Hopkins Day Treatment 1001 Hwy 7 Hopkins, MN 55305 Main #: 952-426-6600

Brooklyn Center Day Treatment 5910 Shingle Creek Parkway Brooklyn Center, MN 55430 Main #: 763-569-5201

IMPORTANT: If your child is experiencing COVID-19 symptoms, staff are not allowed to send student(s) back on their transportation at the end of the day. Parents must make alternate transportation arrangements. Staff are required to inform drivers that a student/passenger is experiencing symptoms.

Attached is the in-person weekly schedule for Day Treatment. You can expect additional communication from District 287 about classroom instruction. We thank you for your continued patience and commitment to the Headway Day Treatment team. The health and safety of everyone is of utmost importance to us and we will continue to be dedicated to the service and delivery of our students and families.

Please keep in mind, this information may change at any given time due to unforeseen COVID-19 cases and/or new information or directives from Headway, District 287, state or local agencies. If you have any questions or concerns around the following safety guidelines, we ask that you contact your child's treatment team immediately.

Cordially,

Day Treatment/District 287 Team Headway Emotional Health



Headway's Day Treatment Safety Guidelines and Protocols

- 1. Headway and District 287 staff will abide by all COVID-19 precautions for being on location/in-person. These expectations will align with the safety guidelines set by the Center for Disease and Control (CDC), the MN Department of Health, and counties and school districts data. Please be advised that this information may change at any given time due to unforeseen COVID-19 cases and/or new information or directives from Headway, District 287, state or local agencies. If you have any questions or concerns around the following safety guidelines, we ask that you contact your child's treatment team immediately.
- 2. Headway staff are collaborating with District 287 administrators to ensure the safety of all students and families are our top priority.
- 3. In addition to building protocols, we as a day treatment and academic team are abiding by the following guidelines:
 - a. If student shows symptoms at programming:
 - i. Student will be asked to enter designated isolation room.
 - ii. Staff will contact student's parents/guardian.
 - iii. Parent and/or guardian will need to make alternative transportation plan.
 - iv. Student must quarantine at home for 14 days, or show they tested "negative" for COVID-19.
 - b. If a student or staff member tests positive for COVID-19, all day treatment staff, students and families will be notified (no identifying information will be disclosed).
 - c. Headway staff will not meet with a student for an in-person session **IF** the student is exhibiting symptoms. If a student is exhibiting symptoms, we ask they do not attend in-person programming. Students must quarantine for 14 days, be symptom free, and/or show proof of a negative COVID-19 test. During time of quarantine, students can attend the online option of programming. Information on COVID-19 symptoms can be found here: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

d. Social Distancing

i. All Headway and school staff must abide by social distancing when at their program/school site. This includes configuring offices and classrooms in such a way to allow for 6 feet of distance between therapist and students for sessions. If an office or classroom does not allow for 6-foot distance between therapist and client, staff will utilize a larger classroom for therapy sessions.

e. Masks

- All Headway and school staff are required to wear a mask when facilitating an indoor inperson session that takes place with a student/family. This is regardless of the social distance that can or cannot be maintained.
- ii. Students and families are also required to abide by the masking policy and are expected to wear a mask at all times. Students who refuse to wear a mask (for non-medical reasons) during in-person programming, staff will immediately contact parents/guardians. Student will not be allowed to return to the building until student can abide by mask policy. Continued refusal may result in an untimely discharge from program.
- iii. If a client has a medical exception to wearing a mask, in-person sessions will only be offered if a space is available to allow for 10 feet of social distance. If this space is not available, then Telehealth sessions will be offered.
- iv. When a therapist is alone in their office, they are not required to wear a mask.

- v. Masks are encouraged, but not required for outdoor sessions, if social distance can be maintained. If social distance cannot be maintained, masks must be worn.
- vi. Masks must be considered adequate (meet CDC guidelines) and appropriate (no inappropriate print or messaging).

f. Disinfecting

- i. Every office and classroom space will have the same disinfecting process and sanitizing stations
- ii. Offices and classroom spaces will be disinfected and cleaned after each group enters and exits the space.
- iii. Students will be asked to use hand sanitizer as they enter and exit every office and classrooms.
- iv. Staff will be limiting the number of students at a time when using the building restrooms. Students should be using hot water and soap when using facilities.
- v. Headway and school staff will disinfect their offices/classrooms between each in-person session. Disinfecting supplies will be provided.
- vi. Students will remain in their community groups throughout the entire day and will not be moving from room to room as in previous years. This is to help limit the contamination, spread, and risk possibilities between staff and students. Headway staff and Teachers will be entering the group and classrooms on the hour to provide instruction as necessary. In addition, the classrooms will have all desks 6 feet apart and facing the same direction. Staff and students will be expected to utilize sanitizer on the way in and out of every room, every time

If your child or family member is exposed to COVID-19 or think you have been exposed.

How do I know if I've been exposed to COVID-19?

You can get exposed when you come into direct contact with the secretions (droplets) of someone who has COVID-19 (being coughed or sneezed on, kissing, sharing utensils, etc.). People often get exposed by a household member or through close contact with another person. Close contact means that you have been within 6 feet of someone with COVID-19 for 15 minutes or more. Some people get COVID-19 without knowing how they were exposed.

If your child or family member had close contact with someone who has COVID-19 but student or family member is not sick. What should you do?

Students and/or family members should stay home for 14 day. During this time, student is able to attend virtual programming/telehealth at the time of quarantine. Check for fever, cough, and shortness of breath for 14 days from the last day you had close contact with the person.

If your child or family member had close contact with someone who tested positive for COVID-19 and now I'm sick. What should I do?

If you were exposed to COVID-19 and get symptoms, you should stay home for 14 days. It is also recommended that you stay away from other people, including household members (self-isolate), even if you have very mild symptoms. Contact your health care provider for a test. Tell them you were exposed to someone with COVID-19 and are now sick.

If student or a family member in the home have suspected COVID-19 symptoms or been exposed to someone with positive COVID-19 test:

- Contact Headway staff immediately!
- Quarantine self for 14 days.
- Students and family members are not allowed to return to in-person programming until you are no longer experiencing symptoms and/or you show proof of a "negative" COVID-19 test.

 During time of quarantine, students and families can attend virtual programming, including individual and family sessions via telehealth. Arrangements will be made on an individual basis with your child's treatment team.

When student can return to in-person program after experiencing symptoms or been exposed to COVID-19:

- It's been at least 24 hours with no fever without using fever-reducing medication, AND
- · Your symptoms have improved, AND
- At least 14 days since symptoms first appeared, AND
- Show proof of a "negative" COVID-19 test from a health care professional.

If students test positive for COVID-19, even if students are not experiencing symptoms:

- Contact Headway staff immediately!
- Isolate self for 14 days.
- Students are not allowed to return to in-person programming until student completes the following: (1) isolate for 14 days (2) are symptom free and (3) show proof of a "negative" COVID-19 test.
- During time of isolation students and families can attend virtual programming, including individual and family sessions via telehealth. Arrangements will be made on an individual basis with your child's treatment team.

When a student can return to in-person program after positive COVID-19 test:

- It's been at least 24 hours with no fever without using fever-reducing medication, AND
- At least 14 days of isolation have passed since the date of student's first positive COVID-19 test, AND
- Student has had no subsequent illness, AND
- Student's symptoms have improved, AND
- At least 14 days since symptoms first appeared, AND
- Show proof of a "negative" COVID-19 test from a health care professional, AND
- Headway staff and family have mutually agreed that student can return to in-person programming.

What's the difference between isolation and quarantine?

- Isolation is what you do if you have COVID-19 symptoms or have tested positive for COVID-19.
 Isolation means you stay home and away from others (including household members) for the recommended period of time to avoid spreading illness.
- Quarantine is what you do if you have been exposed to COVID-19. Quarantine means you stay home
 and away from others for the recommended period of time in case you are infected and are
 contagious. Quarantine becomes isolation if you later test positive for COVID-19 or develop COVID-19
 symptoms.

If you have any questions or concerns about the aforementioned COVID-19 safety precautions or guidelines, please contact your student's treatment team immediately!

Resources:

Guidelines from MN Department of Health for when you have symptoms: https://www.health.state.mn.us/diseases/coronavirus/schools/exguide.pdf

Guidelines from the CDC about when to quarantine:

https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine.html#:~:text=You%20should%20stay%20home%20for,after%20exposure%20to%20the%20virus



Day Treatment Transportation Guide

Transporting students to and from day treatment can be one of the more challenging aspects for families to navigate. Please use this guide as a reference for getting started in making your decision on how to best transport your child to the program.

- School Program Hours: 8:00 AM 2:00 PM
 *These hours are subject to change throughout the school year due to COVID-19 guidelines and protocols.
- > Drop off is between 7:45 AM to 8:00 AM
- > Pick up will be at 2:00 PM

IF YOUR STUDENT HAS MEDICAL ASSISTANCE:

For students with MA, it is advisable that the family use this option. Call the customer service number located on the back of your insurance card to arrange for transportation to and from Headway. It is imperative that you call as soon as you can, as it can take several days to get this set up for your student. Be sure to inform them that the ride is "medically necessary" when you call and give the accurate times for drop-off and pick up. Scheduling changes and informing transportation that your child may be sick, etc. is fully the responsibility of the family.

IF YOUR STUDENT DRIVES OR IS BEING DRIVEN BY A PARENT/ GUARDIAN:

Students who are of age may drive themselves to and from programming and must abide by the following rules:

- · Students must park in the front of the building.
- Students must turn keys into phone locker or staff upon arrival.
- Students are NOT ALLOWED to transport any other students.

Driving to program is considered a privilege and if a student is found to be in violation of the "Transportation Agreement" the following steps will take place:

- First Violation: Parents/Guardians will be contacted and a meeting with take place with the student, parents, and appropriate Headway staff. Parents/Guardians will explore alternative options for transportation and a decision will be made about driving privileges.
- Second Violation: Parents/Guardians will be contacted and the student will no longer have driving privileges to and from program. Parents/Guardians must set up alternative transportation through home school district. No Exceptions.

IF THE ABOVE DO NOT APPLY:

School Year Programming: Students are provided transportation through their school district during the school year and it is the parent/guardian's responsibility to set up transportation through the appropriate school district. Families are advised to be familiar with their school district's transportation policies and procedures. It will be the family's responsibility to coordinate with the school district on scheduling changes, absences, etc. (See back for district contact information)

Summer Programming: Headway provides transportation for students who aren't on MA and don't already drive themselves to and from programming each day. Your student will automatically be placed on a Headway route once

summer begins. You will be notified in advance of the pick-up and drop-off times. It is the family's responsibility to be aware of and follow through on the following Headway transportation procedures.

- Families are to call the attendance line with as much prior notice as possible if the student will not be attending programming.
- Due to traffic and summer construction students need to be ready and waiting at least 15 minutes before and after the scheduled pick-up time.
- Headway will contact families ASAP in regard to possible schedule changes that may arise.
- If a student misses his/her transportation three times he/she will be taken off the route and the family will
 need to meet with the program coordinator in order for the student to be placed back on the route.

Regardless of how your child gets to Headway it is expected that parents call the attendance line if your child will be absent from programming, (Hopkins: 952-426-6613) (Brooklyn Center: 763-569-5202)

School District Transportation Departments

HOPKINS		BROOKLYN CENTER	AS FISS VIEW TAXA
Apple Valley	651-423-7891	Anoka-Hennepin	763-506-1125
Bloomington	952-681-6508	Brooklyn Center	763-450-3386, ext.1201
Buffalo	763-682-8722	Golden Valley	763-504-8027
Burnsville	952-707-2083	New Hope	763-504-8027
Eagan	651-423-7685	Minneapolis	612-668-2300
Eden Prairie	952-975-7043	Osseo	763-391-7244
Edina	952-975-7043	Robbinsdale	763-504-8027
Golden Valley	763-504-8027	Columbia Heights	763-528-4424
Hopkins	952-988-4044	Park Center	763-569-7689
Lakeville	952-232-2025	Moundsview	651-621-6021
Minneapolis	612-668-2300	Elk River	763-241-3546
Minnetonka	952-401-5023	Fridley	763-502-5000
New Hope	763-504-8027	Centennial	763-792-5202
Osseo	763-391-7244	St. Michael	763-497-3180
Plymouth	*call Wayzata, Robbinsdale, Osseo or Hopkins	St. Francis	763-753-0927
Richfield	612-798-6066		
Robbinsdale	763-504-8027		
Rosemount	651-423-7891	- A N	
St. Louis Park	952-928-6741		
Savage	952-226-0033	Three last control of the second	
South St. Paul	651-457-9496		
St. Paul	651-744-1956		
Wayzata	763-745-5195		

Headway Day Treatment

2020-2021 Program Calendar

September 2020									
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No School/Programming



Programming Only (No School): 9:00 AM – 12:00 PM Monday, April 12 (possible "make-up" day due to weather)



Holiday



Academic Year Program Hours: 8:00 AM - 2:00 PM



First/Last Day of School

"Dates in Red" indicate end of Quarters

2020-2021 Family Calendar

Intermediate District 287

DESPONSIVE INNOVATIVE SOLUTIONS

July 2020				Enjoy your summer break! 1: Winter break - no school			January 2021								
Su	M	Т	W	Th	F	Sa	1	4: 1st day back for students after	Su	M	Т	W	Th	F	Sa
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							Enjoy your summer break!	1: Start of 3rd quarter			ebru				
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		pter	nbei		*		8: First day of school	12: No school			Mar	ch 2	021		
Su	M	T	W	Th	F	Sa	Start of 1st quarter	29-31: No school – Spring break	Su	M	Т	W	Th	F	Sa
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	(Octo	her :	2020			2: No school	1-2: No school – Spring break			Ap	ril 2	021		FE
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الخبري		oven			-	أبات	12: End of 1st quarter	31: Memorial Day - no school		5000		y 20			
Su	M	T	W	Th	F	Sa	13: No school 16: Start of 2nd quarter		Su	M	T	W	Th	F	Sa
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EL.	D	ecen	nber	202	0		23-31: Winter break - no school	10: Last day of school			Jui	ne 2	021		17
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27	28	29	30	31			Special day (see description)				29	30			
	Weekend/Summer														

Headway Day Treatment

COVID-19 Student Screening Process

If student answers "yes" to any of the questions, please radio for Coordinator or Supervisor for further assessment

HELP STOP THE SPREAD

HEALTH SCREENING QUESTIONS

- Have you been in close contact with a confirmed case of COVID-19?
- Are you experiencing a cough, shortness of breath, or sore throat?
- Have you had a fever in the last 48 hours?
- Have you had a new loss of taste or smell?
- Have you had vomiting or diarrhea in the last 24 hours?
- Are you currently waiting for results from a COVID-19 test?

NOTE: Members will not be allowed to enter while test results are pending.



ISD 287, School 527 (Headway Academy South) 2020-2021 Student & Family Handbook

Greetings students, parents, and guardians! Teachers are excited to begin the school year with you! Please read over this handbook before school starts next week. Contact your advisory teacher if you have any questions about it.

What will school look like this year?

- "Connected Learning" online-only start date: Tues, Sept. 8
- Expected "In-person Learning" start date: Mon, Sept. 28 (This is subject to change in accordance with state and district guidelines)

Questions about therapy programming or transportation when In-person learning starts?

Please refer to your Headway mental health worker or therapist.

What technology is needed for school work?

- Daily access to a laptop or desktop computer with a keyboard and the internet are necessary- Please let your advisory teacher know if you do not have these things.
- Headphones or earbuds are strongly recommended.

How will teachers communicate with students and parents?

- Students- Live zoom classes each day and email. Communication by a phone call or text message are also options (If okayed by a parent/guardian).
- Parents/guardians- Major school announcements will be sent out by email. Besides this, advisory teachers will contact families of students three times per week to answer questions and/or give updates. If a student misses a class two or more times a week, parents/guardians will be notified. Phone calls or text messages are also options if indicated by parents/guardians as a preference.
- Students, parents/guardians are always welcome and encouraged to contact teachers with questions or concerns! Teachers are available Mondays- Fridays from 7:30 am-3:30 pm to respond.

Live Zoom Classes

 Teachers will be having live Zoom classes every day for students to attend during "Connected Learning". Students will attend Zoom classes with their community members. A different schedule for "In-person Learning" will be sent out closer to our transition at the end of September.

Live Zoom Class Schedule (Connected Learning 9/8- 9/25)

	Made		
8-9 AM	Kate's community- Math		
1st hour	Patrick's community- Science		
	Niki's community- English Caitlyn's community- Social Studies		
	Califyri's community- Social Studies		
9- 12 All students in online therapy programming			
12-12:30 Lunch			
12:30-1:30	Kate- Science		
2nd hour	Patrick- English		
	Niki- Social Studies		
	Caitlyn- Math		
1:30-2:30	Kate- English		
3rd hour	Patrick- Social Studies		
	Niki- Math		
	Caitlyn- Science		
2:30-3:30	Kate- Social Studies		
4th hour	Patrick- Math		
	Niki- Science		
	Caitlyn- English		
	See that I was a second with the second seco		

What are the expectations for live Zoom classes?- STUDENTS, PLEASE READ CAREFULLY

- Students are expected to attend every day and on time unless they have a scheduled therapy session- Please email the teacher if this happens.
- Have your laptop camera on when requested by the teacher. Make sure your face is visible on the camera.
- If prompted by the teacher, respond/participate verbally during an in-class discussion or activities.
- Ask questions and for clarification from the teacher if something doesn't make sense.

- Use school-appropriate behavior on camera- Avoid swearing, making triggering comments, and be respectful towards the teacher and classmates.
- Be aware of the space behind you- Make sure things that would be against school/therapy policy or could be triggering will not appear in the background of your video feed- Feel free to upload/use a Zoom background that is school appropriate.
- Protect the confidentiality of your classmates- Avoid having your screen in a place where family members or other people living with you can see your classmates' faces and names.
- Use headphones or earbuds to block out distractions at home and help stay focused on class.
- Mute yourself when you are not talking.

Use of Google Classroom

- Teachers will be posting all assignments in Google Classroom for students to complete.
- Students will utilize Google Classroom to complete assignments using their ISD 287 user ID and password- It is the same if you were enrolled at our school last year. If you are new, this information will be given to you by your advisory teacher.
- Assignments that have been graded will be returned to students through Google Classroom- Students will get a notification when something has been returned to them.
- Students will be enrolled in the classes they need in Google Classroom by their teacher.
- One Google Classroom is called "Headway Student Announcements." This is where teachers will post important school-wide announcements.

Student work completion expectations

- Students are expected to complete assignments to the best of their ability and turn them in on time as indicated by the teacher.
- Students are expected to complete their own assignments in their own words. Copypaste from websites is not accepted.
- Students are encouraged to ask for help from teachers if they need it during live Zoom classes. Email, text messages, or phone call are also options.
- To practice meeting due dates, there will be a "hard deadline" for turning in all
 assignments for all classes every three weeks. Teachers strongly encourage students
 to turn in their assignments daily or weekly to keep up and to avoid unneeded
 stress on hard deadline day.

Use of school email- VERY important!

- Students will check their school email each day to get their daily links to attend their Zoom classes.
- Students will check their school email daily to view and respond to communications from teachers.
- Students will avoid using school email or Google chat for personal messages to friends or family members.

Responsible laptop/internet use- STUDENTS please read carefully!

- If you have a school district laptop, do not download programs onto it unless it is okayed by a teacher or therapy staff.
- Please turn off any music and videos while the teacher is giving instructions in a Zoom class.
- Listening to music is okay when a teacher gives you independent work time. Limit your time spent getting your playlist ready during work time to no more than 3 minutes.
 Watching videos, movies, or TV shows that are not an assignment for class is not allowed during independent work time.
- When you are logged in under your school Google account, the school staff have the ability to see, monitor, and send messages to your screen- Present and past. During school time, please stay on appropriate websites directly related to your assignments.

Grading and work completion

Work completion can be viewed in Google Gradebook. Final grades will be posted on a
website called "StudentVue" When final grades are ready, families will be notified and
given login information.

School staff contact information (Monday- Friday 7:30 am- 3:30 pm)

Staff	Role	Email	Google Phone/Text
Ms. Jackson (Niki's Community Advisor)	English	cajackson@district287.org	(952) 374-5704
Mr. Rantanen (Caitlyn's Community Advisor)	Social Studies	pgrantanen@district287.org	(952) 374-5705

Ms. Reidt	School Counselor	tlreidt@district287.org	(952) 374-5796
Ms. Sward	EA	nesward@district287.org	
Ms. Stefan	Special Ed	tlstefan@district287.org	(952) 374-5706
Ms. Thoen (Kate's Community Advisor)	Math	apthoen@district287.org	(952) 374-5707
Mr. Zimbric (Patrick's Community Advisor)	Science	jmzimbric@district287.org	(952) 374-5708

Client Name (Last, first, middle initial)							
Street Address		City	State		Zip		
Date of Birth	Day	/ Phone #	Ever	ning Phone #			
INFORMATION RELEASED FRO	M/ EXCHANGE W	TH	INFORMATION RELEASE	D TO/ EXCHAI	NGE WITH		
Name (Program / Individual)			Name (Program / Individu	ıal)			
Headway Academy / Interm		District 287	Headway Emotional H	lealth			
Street Address			Street Address				
5910 Shingle Creek Pkwy,			5910 Shingle Creek P				
City Brooklyn Center	State MN	Zip 55430	City Brooklyn Center	State MN	Zip 55430		
Telephone: 763-569-5200		763-569-5201	Telephone: 763-569- 5		The state of the s		
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AUTHORIZATION	TO DISOLUCE	MEDIOAE / DIEEM	TO INI ORIMATION TO LIMI				
☐ Admission / Intake Summary ☐ Psychiatric Assessment ☐ Prior Treatment Records ☐ Medical/Physical History ☐ Billing Records/Statements (dawn of the cords) ☐ Other: Written or ver	Chemica	on Management Recon n Records	☐ Progress Notes ation /Abuse/Drug/Alcohol Trea ords ☐ Psychological Asses ☐ Progress Review	atment ssment	☐ Discharge Summary ☐ HIV History		
-OR- The entire record (including, including) including billing records	if applicable, chemi <u>excluding</u> l	ical dependency/drug billing records 🔲	g or alcohol abuse treatment re excluding records from other	ecords) facilities	excluding HIV records		
THIS INFORMATION IS TO BE DISCLOSED FOR THE PURPOSE OF: Insurance Payment							
NOTE: A FEE MAY BE CH	ARGED IN AC	CORDANCE WIT	TH MN STATUTE 144.33	S5 AND FED	DERAL RULE 164.524		
I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Please see your Notice of Privacy Practices for information on how to revoke this authorization. I also understand that this authorization will automatically expire one year from the date of my signature unless I revoke it earlier. Headway Emotional Health Services will not refuse or restrict my treatment if I choose not to sign this authorization. A photocopy / fax of this authorization will be treated in the same manner as an original.							
Further, I realize that Headway Emotional Health Services cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore, Headway Emotional Health Services is released from any and all liability resulting from re-disclosure. You are entitled to a copy of this document.							
Client / Legal Representative S	ignature		Dat	е			

Client Name (Last, first, middle initial)							
Street Address	City	State	Zip				
Date of Birth	Day Phone #	Evening Ph	one #				
INFORMATION RELEASED FROM/ EX	CHANGE WITH	INFORMATION RELEASED TO/	EXCHANGE WITH				
Name (Program / Individual)		Name (Program / Individual)					
Resident School District		Headway Emotional Health					
Street Address		Street Address					
		5910 Shingle Creek Pkwy,	Suite 150				
City Stat	e Zip	City	State Zip				
		Brooklyn Center	MN 55430				
	Fax:	Telephone: 763-569-5200	Fax: 763-569-5201				
AUTHORIZATION TO	DISCLOSE MEDICAL / BILLIN	G INFORMATION IS LIMITED T	O THE FOLLOWING:				
Admission / Intake Summary Diagnosis & Treatment Plan Progress Notes Discharge Summary Psychiatric Assessment Chemical Dependency Evaluation /Abuse/Drug/Alcohol Treatment Prior Treatment Records Medication Management Records Psychological Assessment Medical/Physical History Education Records Progress Review HIV History Billing Records/Statements (date): Other: Current IEP, including any behavior intervention plans; 3yr. Special Education Assessment documentation; Transcript and Grades; Health and Immunization Records; Minnesota Basic Skills Test Scores; Attendance and Discipline Records							
-OR- ☐ The entire record (including, if appl AND ☐ including billing records ☐	icable, chemical dependency/drug] excluding billing records	or alcohol abuse treatment records) excluding records from other facilities	s <u>excluding</u> HIV records				
THIS INFORMATION IS TO BE DISCLO ☐ Insurance Payment ☐ Third I☐ ☐ Coordination of Care ☐ Litigat	Party Authorization and Payment	Communication regarding le	egal issues				
NOTE: A FEE MAY BE CHARG	ED IN ACCORDANCE WIT	H MN STATUTE 144.335 AN	D FEDERAL RULE 164.524				
I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Please see your Notice of Privacy Practices for information on how to revoke this authorization. I also understand that this authorization will automatically expire one year from the date of my signature unless I revoke it earlier. Headway Emotional Health Services will not refuse or restrict my treatment if I choose not to sign this authorization. A photocopy / fax of this authorization will be treated in the same manner as an original. Further, I realize that Headway Emotional Health Services cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore, Headway Emotional Health Services is released							
from any and all liability resulting fro	m re-disclosure. You are entitle	ed to a copy of this document.					
Client / Legal Representative Signat	ure	Date					

Client Name (Last, first, middle initial)							
Street Address		City	State	Ziį)		
Date of Birth	Day	Phone #	Evening	Phone #			
INFORMATION RELEASED FRO	M/ EXCHANGE WI	TH	INFORMATION RELEASED TO		E WITH		
Name (Program / Individual)	N.		Name (Program / Individual)				
Mental Health Provider			Headway Emotional Hea	lth			
Street Address			Street Address				
·			5910 Shingle Creek Pkw	A CONTRACTOR OF THE PARTY OF TH			
City	State	Zip	City Brooklyn Center	State MN	Zip 55430		
Telephone:	Fax:		Telephone: 763-569-520	00	Fax: 763-569-5201		
AUTHORIZATION	TO DISCLOSE	MEDICAL / BILLIN	G INFORMATION IS LIMITED	TO THE FO	LLOWING:		
Admission / Intake Summary Psychiatric Assessment Prior Treatment Records Medical/Physical History Billing Records/Statements (date): Other: Written or verbal communication Diagnosis & Treatment Plan Progress Notes Progress Notes Discharge Summary Progress Notes Sprogress Notes Progress Review Discharge Summary Progress Review HIV History							
-OR- The entire record (including, if applicable, chemical dependency/drug or alcohol abuse treatment records) AND including billing records excluding billing records excluding records excluding records excluding records excluding excluding excluding to excluding the excluding to excluding the excluding to excluding the exclusion that excluding the exclusion the exclusion that exclusion the exclusion the exclusion that exclusion the exclusion the exclusion that exclusion the exclusion that exclusion the exclusion the exclusion that exclusion the exclusion that exclusion the exclusion that exclusion the exclusion the exclusion that exclusion the exclusion that exclusion the exclusion that exclusion the							
THIS INFORMATION IS TO BE DISCLOSED FOR THE PURPOSE OF: Insurance Payment							
NOTE: A FEE MAY BE CH	ARGED IN ACC	CORDANCE WIT	H MN STATUTE 144.335	AND FEDER	RAL RULE 164.524		
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Client / Legal Representative S	ignature		Date				

Client Name (Last, first, middle initial)							
Street Address City	State Zip						
Date of Birth Day Phone #	Evening Phone #						
INFORMATION RELEASED FROM/ EXCHANGE WITH	INFORMATION RELEASED TO/ EXCHANGE WITH						
Name (Program / Individual)	Name (Program / Individual)						
Primary Care Physician	Headway Emotional Health						
Street Address	Street Address						
	5910 Shingle Creek Pkwy, Suite 150						
City State Zip	City State Zip Brooklyn Center MN 55430						
Telephone: Fax:	Telephone: 763-569-5200 Fax: 763-569-5201						
AUTHORIZATION TO DISCLOSE MEDICAL / BILL	ING INFORMATION IS LIMITED TO THE FOLLOWING:						
 ☑ Prior Treatment Records ☑ Medication Management Records ☑ Education Records ☑ Billing Records/Statements (date): ☑ Other: Written or verbal communication 	uation /Abuse/Drug/Alcohol Treatment cords Psychological Assessment Progress Review HIV History						
-OR- ☐ The entire record (including, if applicable, chemical dependency/dread AND ☐ including billing records ☐ excluding billing records ☐							
THIS INFORMATION IS TO BE DISCLOSED FOR THE PURPOSE OF: Insurance Payment							
NOTE: A FEE MAY BE CHARGED IN ACCORDANCE W	ITH MN STATUTE 144.335 AND FEDERAL RULE 164.524						
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Client / Legal Representative Signature	Date						

Client Name (Last, first, middle ini	tial)	-					
Street Address		City	State		Zip		
Date of Birth	Day F	Phone #	Ever	ning Phone #			
INFORMATION RELEASED FRO	M/ EXCHANGE WIT	H	INFORMATION RELEASED	D TO/ EXCHA	NGE WITH		
Name (Program / Individual)			Name (Program / Individu	ıal)			
Psychiatrist			Headway Emotional H	lealth			
Street Address			Street Address				
			E010 Shingle Crock B	laur Cuito	150		
City	State	Zip	5910 Shingle Creek P	State	Zip		
Oity	Oldic	Ζip	Brooklyn Center	MN	55430		
Telephone:	Fax:		Telephone: 763-569-5	5200	Fax: 763-569-5201		
AUTHORIZATION	TO DISCLOSE M	EDICAL / BILLIN	G INFORMATION IS LIMIT	TED TO THE	FOLLOWING:		
□ Admission / Intake Summary □ Psychiatric Assessment □ Prior Treatment Records □ Medical/Physical History □ Billing Records/Statements (dawn of the cords) □ Written or ver	☐ Chemical D ☐ Medication ☐ Education F ate):	Management Reco Records	□ Progress Notes tion /Abuse/Drug/Alcohol Trea ords □ Psychological Asses: □ Progress Review	atment sment	☑ Discharge Summary ☐ HIV History		
-OR- The entire record (including, if applicable, chemical dependency/drug or alcohol abuse treatment records) AND including billing records excluding billing records excluding records from other facilities excluding HIV records THIS INFORMATION IS TO BE DISCLOSED FOR THE PURPOSE OF: Insurance Payment Third Party Authorization and Payment Communication regarding legal issues							
Coordination of Care	itigation	er:			==-		
NOTE: A FEE MAY BE CH	ARGED IN ACC	ORDANCE WIT	H MN STATUTE 144.33	5 AND FED	ERAL RULE 164.524		
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Client / Legal Representative Si	ignature		Date)			

Client Name (Last, first, middle initial)							
Street Address City	State Zip						
Date of Birth Day Phone #	Evening Phone #						
INFORMATION RELEASED FROM/ EXCHANGE WITH	INFORMATION RELEASED TO/ EXCHANGE WITH						
Name (Program / Individual)	Name (Program / Individual)						
	Headway Emotional Health						
Street Address	Street Address						
	5910 Shingle Creek Pkwy, Suite 150						
City State Zip	City State Zip Brooklyn Center MN 55430						
Telephone: Fax:	Telephone: 763-569-5200 Fax: 763-569-5201						
	G INFORMATION IS LIMITED TO THE FOLLOWING:						
	☐ Progress Notes ☐ Discharge Summary Ition /Abuse/Drug/Alcohol Treatment Progress Review ☐ HIV History ☐ HIV History						
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Coordination of Care Litigation Other:							
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Client / Legal Representative Signature	Date						