SOUTH DAKOTA DEPARTMENT OF CORRECTIONS POLICIES AND PROCEDURES		POLICY NUMBER 1.5.H.15	PAGE NUMBER 1 OF 7
		DISTRIBUTION: Public	
		SUBJECT: Juvenile Intake Process	
RELATED STANDARDS:	None	EFFECTIVE DATE: June 01, 2023	
		SUPERSESSION: 10/13/2021	
DESCRIPTION: Admission and Orientation	REVIEW MONTH: May	**KELLIE WASKO** **SECRETARY OF CORRECTIONS**	

I. POLICY

It is the policy of the South Dakota Department of Corrections (DOC), Juvenile Division, to have an established intake process for juveniles which assesses the level of care necessary and educates the juvenile and his or her family on the procedures while also answering any questions and eliminating any misconceptions.

II. PURPOSE

The purpose of this policy is to define the process to be followed in the intake of juveniles.

III. DEFINITIONS

Integrated Word Processing Document (IWP):

IWP integrates a standard word processing application (Microsoft Word) with the Comprehensive Offender Management System (COMS) database to produce offender-specific reports/documents. Information from offender records is automatically transferred from the COMS database to IWP documents. After the IWP document is generated, it is saved to the COMS database where it becomes a permanent part of the offender record with a unique ID number and date/time stamp.

South Dakota Foundation for Medical Care Peer Review Organization (PRO):

Provides the medical necessity review process to access Medicaid funding.

State Review Team (SRT):

An interagency team that reviews cases for consideration for Psychiatric Residential Treatment Facility/Intensive Residential Treatment (PRTF/IRT) level of care. The SRT provides a recommendation to PRO regarding eligibility for services.

IV PROCEDURES

1. Notice of Commit:

A. Upon notification of the juvenile's committal to the DOC, the JCA or support staff, must complete the *Notice of Commitment* process (see attachment #1).

B. A copy of the Notice of Commitment form or electronic equivalent must be submitted to the JCA supervisor, accounting assistant at DOC Administration, director of Juvenile Services secretary, Watertown secretary and the director of Juvenile Services.

C. The JCA supervisor will assign the juvenile's case to a JCA.

2. Initial Intake Procedures Checklist:

A. The JCA must complete the *Initial Intake Procedures Checklist* to document the collection of information (see attachment #2).

3. Intake Data Collection Form:

A. The JCA must complete the *Intake Data Collection Form* (see attachment #3) using a variety of sources to include but not limited to court services, law enforcement, state's attorney, prior service providers, parent or guardian, juvenile, and school. This will be entered in COMS by the JCA or support staff within seven (7) days of the commitment.

4. Juvenile Photos:

Upon commitment all offenders will have a photo taken holding the standard juvenile photo placard. The *Juvenile Photo Placard* (see attachment #4) must include the unique juvenile offender identification number generated in COMS.

A. The following standards must be followed for capturing photos:
   1. Offender must stand against a wall free from pictures or other visual distractions.
   2. The juvenile's image must be captured while holding the placard, with a front facial view; left side facial view; right side facial view.
   3. Any scars, marks, or other significant identifying facial features will be captured.

B. All photos must be uploaded into COMS in accordance with the procedures outlined in the COMS user manual.

C. Juvenile photos shall be updated at minimum every two (2) years or earlier if there are significant changes in appearance.

5. Youth Level of Service/Case Management Inventory (YLS/CMI 2.0):

A. The YLS/CMI 2.0 interview will be administered with the juvenile by the JCA.

B. The assessment results will be entered on COMS by the JCA or support staff within seven (7) days of commitment.

C. Any requests for over-rides will be submitted to director of Juvenile Services

6. MAYSI 2:

A. The MAYSI 2 will be administered by the JCA.

B. The assessment results will be scored on juveniles who are ages twelve to seventeen (12-17). The scoring must be done while on-site with the youth, during the intake process. The results will be recorded on the Juvenile Offender Intake Summary under the Mental Health, Emotional Stability, and Functioning Impairment section via the case note functionality in COMS.

C. Juveniles under age twelve (12) or over age seventeen (17) will not be scored. These cases will require individual responses to be reviewed to determine if there is cause for heightened observation or consultation with mental health staff.

D. In cases where the juvenile scores in the warning zone, the JCA shall complete the Second Screening forms. The JCA shall alert placement staff or others with primary care responsibility of the need for heightened observation.

E. Cases that result in scores in the warning zone will also require the JCA to notify the respective behavioral health staff at the facility being considered for placement via email or phone.

F. Consultation with behavioral health staff will determine if further evaluation is necessary and, if so, the means that will be utilized to accomplish the evaluation.

7. Mental Health Data:

A. The JCA shall complete the Mental Health Data Assessment in COMS for all offenders.

8. Chemical Dependency Data:

A. The JCA shall complete the Chemical Dependency Assessment in COMS for offenders who have a Treatment Needs Assessment (TNA) on file.

9. Sex Offender Identification Data:

A. The JCA shall complete the Sex Offender Identification Assessment in COMS for all juveniles.

10. Placement prior to DOC Commitment Data:

A. The JCA shall complete the Placement Prior to DOC Commitment Data Assessment in COMS for all juveniles.

11. Human Trafficking Screener

A. The JCA shall complete the *Human Trafficking Screener Form* for all juveniles (see attachment #5).

B. In cases where the offender reports they are a victim of human trafficking, notification to appropriate investigative agency should occur consistent with circumstances.

12. Medical Records:

A. The JCA shall inquire about the medical history of the juvenile when conducting the YLS/CMI 2.0 interview.

B. The JCA will also inquire about medical history when meeting with the parent(s) as part of intake interview and to review the Juvenile Living Guide.

C. Upon determining that the juvenile has a history of health-related problems or a current health condition, the JCA shall notify the placement provider so they may plan accordingly.

D. The JCA will also initiate the request for relevant medical records to be sent to the facility.

13. Consent for Release of Information:

A. The JCA must obtain the offender's signature on the *Consent for Release of Information Form* (see attachment #14).

14. Juvenile Intake Summary:

A. The *Juvenile Intake Summary* is used to summarize the intake processes (see attachment #6).

B. The Juvenile Intake Summary is created via the Contact Logs module in COMS. Select Case Note Type "Intake" and all Contact Subtypes with "Intake" prefix to create narrative for summary.

C. A comprehensive Intake Summary must include detailed information on the following areas:
   1. Court History.
   2. Family.
   3. Education/Vocational.
   4. Social.
   5. Substance Abuse.
   6. Mental Health/Emotional Stability/Functioning Impairments/MAYSI 2 results.
   7. Medical/ Insurance.
   8. Prior Interventions.
   9. Aftercare Placement Options.

15. Financial Documentation:

A. Within seven (7) days of commitment, the JCA will submit the following information:
   1. Original DOC Medicaid Application – submitted to director of Juvenile Services secretary.
   2. Court Order of Commitment – submitted to accounting assistant at DOC Administration.
   3. Court Order of Parental Support – submitted to Juvenile Services secretary.
   4. Photocopy of any private insurance card, both front and back of card – submitted to the director of Juvenile Services secretary.
   5. Birth Certificate - submitted to director of Juvenile Services secretary.
   6. Photo ID - submitted to director of Juvenile Services secretary
   7. Updates to any of the above documents.

16. Title XIX:

A. Title XIX, or Medicaid, is a program that pays the medical bills for low-income people who meet the eligibility standards. Medicaid also pays for intensive residential treatment (IRT) and psychiatric residential treatment services for eligible youth. Home Health is a category of Medicaid coverage that youth may be eligible for which requires a primary care provider and referrals for services.
   1. The JCA must complete a *Medicaid Application for Child in Custody* for each offender, including those in a community residential placement and/or aftercare status (see attachment #7). As part of the application process, the JCA will obtain the youth signature to opt out of Home Health coverage by completing the *Medicaid Health Home Declination Form* (see attachment #8).
   2. Upon Notice of Commitment, the JCA must send a fully completed original DOC Medicaid Application, birth certificate, and Photo ID to the director of Juvenile Services secretary.

3. The JCA must update the juvenile's offender address module in COMS and parents, or any court ordered parties responsible for parental support payment in the Personal and Professional Contacts module, as necessary, to ensure that Medicaid notices are received by the eligible youth throughout the commitment process.

B. The DOC will submit the application to the Department of Social Services in Pierre.

17. Parental Support:

A. Parental support will be assessed by the court to the parent/guardian of the offender. Payment will be incurred anytime the DOC is billed for placement of the offender, including home detention in accordance with court order. Payment will be made directly to the DOC in Pierre.
   1. The JCA must document the amount of the parental support on the *Parental Support Information Form* through the IWP process in COMS (see attachment #9)
   2. The JCA must send a copy of the court order and completed Parental Support Information Form stating the parent/guardian name and the parental support amount to the accounting assistant at DOC Administration.

B. Any parental support orders will be reinstated for those offenders who are revoked from aftercare. The JCA will complete the *Parental Support Reinstatement Form* (see attachment #10) through the IWP process in COMS and forward to the Juvenile Services secretary. . The JCA will advise the parent of the right to request a review hearing with the court regarding the amount of parental support originally ordered.

18. Social Security:

A. The JCA will determine if the offender is receiving Social Security benefits by interviewing the offender and his parent/guardian.
   1. If yes:
      a. The JCA must document if Social Security benefits are received on the Parental Support Information Form.
   2. If unable to determine:
      a. The JCA must contact Social Security Regional Office at (866-563-4604) to determine the possibility of benefits. Detailed instructions are available on the Parental Support Information Form to assist you with this call

B. The parent shall be advised of the right to investigate eligibility by contacting the Social Security office or referring to the eligibility manual located at the JCA's office.

19. Social Security Income (SSI):

A. The JCA must document the amount of the SSI on the Parental Support Information form.
   1. If unable to determine:
      a. The JCA must contact Social Security Regional Office at (866-563-4604) to determine the possibility of benefits. Detailed instructions are available on the Parental Support Information Form to assist you with this call.
      b. The parent shall be advised of the right to investigate eligibility by contacting the Social Security office or referring to the eligibility manual located at the JCA's office.

20. Juvenile Living Guide:

A. The Juvenile Living Guide will be issued to every juvenile and parent whose child is committed to the DOC. The Living Guide will provide introductory information regarding the juveniles' commitment to the DOC.

B. The JCA will have the juvenile and parent/guardian complete the Receipt of the Juvenile Offender Living Guide (page 3 of the Juvenile Offender Living Guide). The original will be maintained in the offender's central file.

21. Placement Recommendation Process for Non PRTF Services:

A. Upon completion of the initial intake requirements, the JCA will make a recommendation to their supervisor for placement, consistent with the youth's level of care requirements. Recommendation shall include the following information: juvenile name, commitment date, date of aftercare revocation when applicable, date of birth, current placement location, committing offense, YLS/CMI 2.0 total score and by domain, institutional risk level, mental health diagnoses, previous placements.

B. The following guidelines will be used in determining a placement plan for all Non-PRTF delinquent juveniles:
   1. Group care, community based services, alternative services – males and females with supervisory approval.
   2. When making a referral to a private care facility the JCA should complete a *Group/Residential Referral Application* through the IWP process in COMS and send to the facility with the supporting documents (see attachment #11).

C. The director of Juvenile Services must approve all placements for Non-PRTF services.

22. Placement Recommendation for PRTF/IRT Services:

A. Upon completion of the initial intake requirements, the JCA will make a recommendation to their supervisor for placement, consistent with the youth's level of care requirement. If an offender has a qualifying psychiatric diagnosis and significant behaviors that suggest the need for PRTF/IRT level of care, the JCA should complete a *PRTF Referral Form* (see attachment #12) through the IWP process in COMS. The JCA should submit the form and required supporting documentation to their supervisor and community correction specialist.

B. The file will be reviewed by the State Review Team and forwarded to PRO to determine Medicaid eligibility. The JCA will be notified on the outcome of the review.

C. The director of Juvenile Services must approve all PRTF/IRT services.

23. Reports to the Court:

A. Initial Status Report - The JCA will provide the court with an Initial Status report through the IWP process in COMS. This includes a copy of the written narrative intake summary and a summary of any psychological, psychiatric, medical, physical, or health status information within thirty (30) days after the juvenile's commitment date. (see attachment #13 – *Initial Status Report*).

B. Court Recommendations for Placement - In cases where the committing court provides a specific recommendation for placement, the JCA should give high consideration to the recommendation. In the event the department seeks a placement inconsistent with the court's recommendation, the JCA shall provide personal and immediate notification to the committing court.

V. RESPONSIBILITY

The director of Juvenile Services is responsible for the annual review and maintenance of this policy.

VI. AUTHORITY

None

VII. HISTORY

May 2023
October 2021
October 2020
November 2019
May 2019
May 2019
April 2018
March 2018
March 2017

ATTACHMENTS

1. Notice of Commitment
2. Initial Intake Procedures Checklist
3. Intake Data Collection Form
4. Juvenile Photo Placard
5. Human Trafficking Screener Form
6. Intake Summary Form (generated in JUV COMS)
7. Medicaid Application for Child in Custody
8. Medicaid Health Home Declination Form
9. Parental Support Information Form (generated in JUV COMS)
10. Parental Support Reinstatement Form (generated in JUV COMS)
11. Group/Residential Referral Application (generated in JUV COMS)
12. PRTF Referral Form (generated in JUV COMS)
13. Initial Status Report (generated in JUV COMS)
14. Consent for Release of Information
15. DOC Policy Implementation / Adjustments

State of South Dakota
Department of Corrections
Division of Juvenile Corrections

NOTICE OF COMMITMENT

Juvenile Name	Last				Juvenile ID#			
	First		MI		DOB		Gender	
Prior DOC Commitment(s):								
Date of Commitment :(s)								
Status:								
Judge:			Circuit:					
County								
Delinquent			CHINS					
Child's Location:								
Date Commitment entered into COMS:								

Corrections Agent _____ Date _____

Initial Intake Procedures Checklist

Juvenile Name:		**Juvenile ID:**
DOCUMENT CHECK LIST	**SOURCE**	**COPIES TO:**
☐ Court Orders	Court Services Officer & States Attorney	☐ Intake or Institution DOC ☐ Central Office
☐ Social Case History	Court Services Officer	☐ Intake or Institution
☐ Police/Arrest Reports of current & prior offenses	Court Services Officer & JCA	None
☐ Probation & Aftercare violation reports	Court Services Officer & JCA	☐ Intake or Institution
☐ Signed Release of Information Forms (school, prior placements, medical, mental health, CD)	DOC generated or Private Agency releases	☐ Intake or Institution
☐ Prior placement Case Service Plans, Progress Reports, release summaries	Prior service providers, private & state Court Services Officer	File, SRT, CHINS Committee
☐ Incident reports from prior placements & discharge Summary	Prior service providers, private & state	☐ Intake or Institution
☐ Copy of Birth Certificate	Parents/Guardian	☐ Intake or Institution
☐ Immunization Records	Parents/Guardian/School	☐ Intake or Institution
☐ Insurance Cards (copy front and back)	Parents/Guardian	☐ Intake or Institution ☐ Dir. Of Class. Secretary in SF
☐ tribal Enrollment / District	Parents/Guardians	☐ Intake or Institution
☐ Copy of Social Security Card	Parents/Guardian/Child	☐ Intake or Institution
☐ School Records	School	☐ Intake or Institution
☐ Mental Health Records	Core Service Agency / Provider	☐ Intake or Institution
☐ Medical Records	Parents / Clinic	☐ Intake or Institution
☐ National Sex Offender Registry	☐ https://www.nsopw.gov/	☐ Institution
☐ DNA	☐ https://www.riss.net/	☐ Institution
☐ Victim Information	☐ State's Attorney's Office	☐ Support Staff in Sioux Falls and Rapid City
☐ Human Trafficking Information	Questionnaire	☐ Intake or Institution

INTERVIEW CONTACT CHECKLIST	**PURPOSE**
☐ Court Services Officer	Collect copies of file material & inf. exchange
☐ Prior Service Providers	Collect copies of file material & inf. exchange
☐ Child	Intake Master Form, YLS Interview & information provision
☐ Social Security Administration	Verify SSI and Social Security Benefits
☐ Parents/Guardians	Intake Master Form, parental input summary, collect birth certificate and SS card, inf. Provision

ASSESSMENTS & FORMS TO BE COMPLETED

☐ Intake Data Collection Form	☐ MAYSI-2 Assessment	☐ Parental Support Form
☐ Parent Intake Survey	☐ Contract Health Services (IHS)	☐ Statement of Need - Medicaid (as applicable)
☐ Notice of Commitment	☐ Notice of Transfer	☐ Juvenile Offender Intake Summary
☐ YLS/CMI Assessment	☐ Referral/Recommendation for placement	☐ Offender Living Guide Receipts ☐ Receipt of Acknowledgement from parents
☐ Juvenile Photo / Photo Placard	☐ Human Trafficking Screener	

Juvenile Corrections Agent _____ Date _____

INTAKE DATA COLLECTION FORM

OFFENDER

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

GENDER	RACE	DOB	AGE

ALERTS- Prior Community Interventions

ALERT	ALERT TYPE
COMMUNITY ALERT	☐ YES ☐ NO ☐AB ☐CUR ☐GPS ☐SCR ☐ Warrant Confirmation & Note

Notes:

ALIASES

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

IDENTIFIERS

SOCIAL SECURITY #	DRIVERS LICENSE #	PHOTO ID #	TRIBE	TRIBAL DISTRICT	ENROLLEMENT #

PERSONAL INFORMATION

EYES	HAIR	HEIGHT	WEIGHT	PLACE OF BIRTH	COUNTY OF BIRTH	COUNTRY OF BIRTH

PHYSICAL MARKS:

RELIGIOUS PREFERENCE:

MARITAL STATUS:

CITIZENSHIP	GANG AFFILIATION	NUMBER OF CHILDREN	MEDICAID NUMBER

COMMITTED FROM DSS ☐ YES ☐ NO **DNA REQUIRED**
CHINS ☐ YES ☐ NO ☐ YES ☐ NO
DELINQUENT ☐ YES ☐ NO **DATE COLLECTED**
CHINS/DELINQUENT ☐ YES ☐ NO ____
MILTARY CHILD ☐ YES ☐ NO

ADDRESS/CONTACT INFORMATION

ADDRESS 1
PRIMARY ☐ **MAILING** ☐ **ACTIVE** ☐ YES ☐ NO

NAME **SUITE** **STREET** **CITY** **STATE** **ZIP** **COUNTRY**

LAND LINE **CELL #** **EMAIL**

ADDRESS 2
PRIMARY ☐ **MAILING** ☐ **ACTIVE** ☐ YES ☐ NO

NAME **SUITE** **STREET** **CITY** **STATE** **ZIP** **COUNTRY**

LAND LINE **CELL #** **EMAIL**

ADDRESS 3
PRIMARY ☐ **MAILING** ☐ **ACTIVE** ☐ YES ☐ NO

NAME **SUITE** **STREET** **CITY** **STATE** **ZIP** **COUNTRY**

LAND LINE **CELL #** **EMAIL**

OFFENDERS CONTACTS

CONTACT 1

EMERGENCY	**NEXT OF KIN**	**ACTIVE**	**PRIMARY**	**MAILING**
☐ YES ☐NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

LAST NAME **FIRST NAME** **MIDDLE NAME** **RELATIONSHIP**
SOCIAL ☐
FAMILY ☐

SS # **DOB** **CONTACT TYPE** **FIRST LANGUAGE** **MARITAL STATUS**

SUITE **STREET** **CITY** **STATE** **ZIP** **COUNTRY**

LAND LINE **CELL #** **EMAIL**

CONTACT 2

EMERGENCY	NEXT OF KIN	ACTIVE	PRIMARY	MAILING
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP
		SOCIAL ☐ FAMILY ☐	

SS #	DOB	CONTACT TYPE	FIRST LANGUAGE	MARITAL STATUS

SUITE	STREET	CITY	STATE	ZIP	COUNTRY

LAND LINE	CELL #	EMAIL

CONTACT 3

EMERGENCY	NEXT OF KIN	ACTIVE	PRIMARY	MAILING
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP
		SOCIAL ☐ FAMILY ☐	

SS #	DOB	CONTACT TYPE	FIRST LANGUAGE	MARITAL STATUS

SUITE	STREET	CITY	STATE	ZIP	COUNTRY

LAND LINE	CELL #	EMAIL

CONTACT 4

EMERGENCY	NEXT OF KIN	ACTIVE	PRIMARY	MAILING
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP
		SOCIAL ☐ FAMILY ☐	

SS #	DOB	CONTACT TYPE	FIRST LANGUAGE	MARITAL STATUS

SUITE	STREET	CITY	STATE	ZIP	COUNTRY

LAND LINE	CELL #	EMAIL

CONTACT 5

EMERGENCY ☐ YES ☐ NO **NEXT OF KIN** ☐ YES ☐ NO **ACTIVE** ☐ YES ☐ NO **PRIMARY** ☐ YES ☐ NO **MAILING** ☐ YES ☐ NO

LAST NAME **FIRST NAME** **MIDDLE NAME** **RELATIONSHIP**
SOCIAL ☐
FAMILY ☐

SS # **DOB** **CONTACT TYPE** **FIRST LANGUAGE** **MARITAL STATUS**

SUITE **STREET** **CITY** **STATE** **ZIP** **COUNTRY**

LAND LINE **CELL #** **EMAIL**

CONTACT 6

EMERGENCY ☐ YES ☐ NO **NEXT OF KIN** ☐ YES ☐ NO **ACTIVE** ☐ YES ☐ NO **PRIMARY** ☐ YES ☐ NO **MAILING** ☐ YES ☐ NO

LAST NAME **FIRST NAME** **MIDDLE NAME** **RELATIONSHIP**
SOCIAL ☐
FAMILY ☐

SS # **DOB** **CONTACT TYPE** **FIRST LANGUAGE** **MARITAL STATUS**

SUITE **STREET** **CITY** **STATE** **ZIP** **COUNTRY**

LAND LINE **CELL #** **EMAIL**

EDUCATION

SCHOOL **AREA OF STUDY** **START DATE** **END DATE** **LAST GRADE ATTAINED**
IEP ☐ YES ☐ NO

EMPLOYMENT

EMPLOYER **STATUS** **OCCUPATION** **SUPERVISOR** **START DATE** **END DATE**

WAGE **PERIOD** **SCHEDULE TYPE** **HOURS PER WEEK**
IS EMPLOYER AWARE ☐ YES ☐ NO **CAN EMPLOYER BE CONTACTED** ☐ YES ☐ NO
TERMINATION REASON:

MEDICAL

PRIMARY DOCTOR

DENTIST

BROKEN BONES

HEALTH PROBLEMS

CORRECTIVE LENSES

ALLERGIES

Glasses ☐YES ☐NO **Prescribed By**:
Contacts ☐YES ☐NO
Full time ☐YES ☐NO
Part time ☐YES ☐NO

MEDICATIONS

TYPE OF MED	PRESCRIBED FOR	DOSAGE	PRESCRIBED BY

HEALTH INSURANCE

POLICY HOLDER	POLICY NUMBER	GROUP NUMBER	COMPANY	CITY/STATE

MENTAL HEALTH

CURRENT DSM DIAGNOSIS

DIAGNOSED BY: **DATE:**

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V _____

PRIOR OUT-PATIENT TX

AGENCY	PSYCHIATRIST/COUNSELOR	START DATE	END DATE
AGENCY	PSYCHIATRIST/COUNSELOR	START DATE	END DATE
AGENCY	PSYCHIATRIST/COUNSELOR	START DATE	END DATE

PRIOR IN-PATIENT TX

FACILITY	START DATE	END DATE	REASON
FACILITY	START DATE	END DATE	REASON
FACILITY	START DATE	END DATE	REASON

Date

South Dakota Department of Corrections
Juvenile Division

Name

DOC

DOB:

Human Trafficking Screener Form

Sometimes we don't know what we're involved in until it's too late. This questionnaire will help your JCA identify if you have been a victim of human trafficking and aid in identifying factors that we can work through so you can succeed with the opportunities provided by DOC.

Please mark any items that apply to your current or past situation.

Are you living on your own, with an older partner or are you homeless?	
Does anyone take all or part of the money you earn?	
Do you have debt or owe money to someone you cannot pay off?	
Has anyone ever physically or sexually abused you?	
Has anyone threatened to hurt you or your family if you do not do what they ask?	
Have you ever been forced to engage in sexual acts for money or favors?	
Do you have a feeling of insecurity or feel that you need to answer these questions vaguely?	
Do you feel that you are unable to speak on your own behalf or have someone else answer for you?	

Department of Corrections
Juvenile Intake Summary

Juvenile Name:

JCA:

Juvenile ID:

Judge:

Juvenile DOB:

Address:

Court Narrative

Family Information

Education/Employment

Social

Substance Abuse

Mental Health

Medical

Prior Interventions

Aftercare Placement/Key Issues

Receipt Date: _____/_____/_____ Recipient ID: _____

Department of Corrections
Application for Medicaid for a Child in Custody

1. First Name, Middle Name, Last Name, & Suffix			
2. Address	**3.** City	**4.** State	**5.** Zip Code
6. Date of birth (MM/DD/YYYY)	**7**. Social Security Number (XXX-XX-XXXX)		
8. Sex	9. Race	**10.** Member of a Federally Recognized Tribe (Y/N)	

11. Is this person a full-time student? ☐ Yes ☐ No

12. Are you a U.S. citizen? ☐ **Yes** ☐ No

13. If no, do you have eligible immigration status? ☐ Yes ☐ No

Document Type: _____ Document Number: _____

14. Have you been known by any other name? ☐Yes (If yes, please provide information below**)** ☐ No

15. First Name	**16.** Last Name

USE OF SOCIAL SECURITY NUMBER

The Division of Economic Assistance will use the SSN to verify your income and eligibility for Medical Assistance. It is possible the SSN will be used to determine another person's right to Medical Assistance or to comply with Federal law requiring release of information from medical records. The information may be matched with the records in other agencies, such as the Social Security Administration or Internal Revenue Service. The matches may be done by computer or on an individual basis. This is required by section 1137(a)(I) of the Social Security Act and Medical Assistance regulations at 42CFR 435.910.

Juvenile Correction Agent Information

17. First Name, Middle Initial, & Last Name			
18. Address	**19.** City	**20.** State	**21.** Zip Code

Placement Information

Committal Date: ____/____/____ Placement Date:____/____/_____

Current Placement : _____

Future Placement: _____

Estimated Placement Date:___/_____/_____

Health Insurance Information

22. Are you covered by any health insurance plan? ☐ Yes (Please provide copy of the card☐☐ **No**

23. Name of Insurance Company	**24.** Address of Insurance Company
25. Policy #	**26.** Group #
27. Policy Holder Name	**28.** Date Coverage Began

29. Type of Coverage (Inpatient, Out-Patient, Pharmacy, Dental, Vision, etc.)

Income Information

30. Does the applicant plan to file a tax return? ☐ Yes ☐ **No** (If yes, please provide information below)

31. Monthly Gross Income	**32.** Income Source

READ THE FOLLOWING SECTIONS CAREFULLY BEFORE YOU SIGN AND DATE THIS FORM

CIVIL RIGHTS GUARANTEE

The provisions of the Civil Rights Act of 1964, as amended, also apply to your case and department representatives shall not, on the grounds of race, color, creed, religion, sex, disability, ancestry, or national origin, exclude you from participation in, deny the benefits of, or otherwise subject you to discrimination under any program or activity administered by the department. Any person who feels that his civil rights have been violated may request a fair hearing. You may also file a complaint of discrimination by writing DSS Division of Legal Services, 700 Governors Drive, Pierre, SD 57501-2291 or by calling (605) 773-3305.

PRIVACY STATEMENT

Federal and State laws and regulations limit the use and disclosure of confidential information concerning applicants and recipient of all agency programs to purposes directly related to the administration of these programs.

ASSIGNMENT OF RIGHTS OF PAYMENT FOR MEDICAL SUPPORT AND OTHER MEDICAL CARE

As a condition of my eligibility, I assign to the State any rights to medical support and to payment for medical care from any third party. I agree to cooperate with the State in identifying and providing information to assist the State in pursuing any third party that may be liable to pay for care and services. I understand that I must report any payments received for medical care within ten days.

STATEMENT OF UNDERSTANDING AND AGREEMENT

I understand that, by signing this application, I am agreeing to a review of my eligibility by State and/or Federal officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and review of any agency records. I also agree that my application authorizes these agencies to release to this agency the information needed to determine my eligibility. I agree to provide the documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which this agency may obtain the necessary proof.

I understand that each individual who receives assistance must provide or apply for a social security number. I authorize the use of my (our) social security number for such purposes as identification, program reviews or audits, and computer matching with our other agencies and institutions such as banks, saving and loan associations, and other government agencies, including Internal Revenue Service, to verify eligibility for assistance.

RIGHT TO FAIR HEARING

Right to hearing - If your application for assistance is denied or you do not agree with the action the Department has taken, you may appeal such action. You can have a conference with your Benefits Specialist and receive a full explanation of the proposed action as long as you request the conference within 15 days after this notice was mailed to you.

How to request a hearing - You have the right to request a fair hearing if you disagree with any decision about your application. Hearing requests must be made within 30 days from the date the written notice was received. To request a hearing contact the Office of Administrative Hearings, Kneip Building, 700 Governors Drive, Pierre, SD 57501 (Phone: (605) 773-6851; Fax: (605) 773-6873). The request must indicate what action is being appealed.

Thirty Day Limitation - You may request a fair hearing within (30) days after notice of the proposed action or the conference decision, or thirty (30) days after action should have been taken as provided by law or rule.

Inform your Benefits Specialist of any changes in circumstances that may affect eligibility (income, resources, living arrangement, etc.) These changes must be reported promptly

AUTHORIZATION TO FURNISH INFORMATION AND RELEASE INFORMATION

I hereby authorize any person, agency or institution to supply information requested by the Department of Social Services concerning me or my family, and to allow inspection and reproduction of records in his or their possession pertaining to me or my family by and duly authorized representative of the Department. I further authorize the Department to release such information to providers or cooperating State or Federal Agencies.

The authorization is given only in connection with its use by the Department I the administration of its programs and for no other purposes. It shall continue in effect until such time as I state in writing that it is no longer valid. I hereby release any person, agency or institution from any and all liability to me or my family for supplying such information.

Signature of Applicant: _____ Date: ____/____/____

Signature of Juvenile Correction Agent: _____ Date: ____/____/____

MEDICAID HEALTH HOME
DECLINE TO PARTICIPATE FORM

I understand that I may choose not to participate in the Health Home Program. Please complete this form and return it to the Division of Medical Services, 700 Governors Dr., Pierre, SD 57501.

I choose not to participate in the Health Home Program
Please complete the statement below and return it to the Division of Medical Services, 700 Governors Drive, Pierre, SD 57501, or call (605) 773-3495.

I, _____, do not want to participate in Health Homes at this time.
(Name, Please Print)

I know that I can choose to participate in Health Homes at any time if I am eligible for the program.

_____ _____
Signature Medicaid Number

Reason for declining to participate (Please check all that apply)

____ My provider is not a Health Home Provider

____ I don't understand the program, please call me at _____

____ Other (please explain)
_____
_____
_____
_____

PARENTAL SUPPORT INFORMATION FORM

Juvenile ID #: _____ Date of Birth: _____

Juvenile's Name: _____

Commitment Date: _____ Social Security #: _____

JCA Name: _____ Telephone #: _____

$ _____ Per month or per week (please circle)

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____

Currently paying Child Support: ☐ Yes ☐ No

What State, County or other location is payment made to? _____

$ _____ Per month or per week (please circle)

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____

Currently paying Child Support: ☐ Yes ☐ No

What State, County or other location is payment made to? _____

Date Support Begins: _____
(Beginning date is Date of Commitment plus seven days)

Notes: _____

****Call Rapid City Social Security Administration at (866-354-1123): Dial the appropriate extension according to the juvenile's last name to verify whether the child is eligible to receive benefits (will be prompted for child's SSN and date of birth). AA-LA=Ext. 13920 and LB-ZZ=Ext. 13914.**
Call the Accounting Assistant in Pierre for any needed assistance.

Juvenile receiving SS: ☐ Yes ☐ No Juvenile receiving SSI: ☐ Yes ☐ No

This form and a copy of the Court Order stipulating parental support is to be sent to DOC Administration Office for new commitments and for offenders whose aftercare has been revoked.

State of South Dakota
Department of Corrections

PARENTAL SUPPORT REINSTATEMENT FORM

TO:

FROM:

RE: Parental Support Reinstatement

DATE:

Please be advised the amount of $_____ per week/month (circle one) for parental support has been reinstated due to the aftercare revocation of _____ effective _____.

The Payment should be sent to:

Department of Corrections
3200 East Highway 34 Suite 6
c/o 500 East Capitol Avenue
Pierre, SD 57501-5070
Attn: Accounting Department

(When sending payments, please make a note on the check or money order with your child's name: First, Middle Initial and Last). If you have any questions or concerns, please feel free to contact me at the above address or number.

cc: File
Jeannell Scott

Department of Social Services - Child Protection Services
South Dakota Department of Corrections
Group/Residential Referral Application

Juvenile Name: **Gender:** **Race:**

Date of Birth: **Social Security Number:** **Height:** **Weight:**

Medicaid Number: **CID Number:**

Discharge Plan: **Permanent Plan:**

Level of Service – Please check the level of service that is being sought for the youth.

Community Based Services	NON-PRTF SERVICES	PRTF SERVICES
☐ Out of School Time	☐ Short Term Assessment	☐ Residential Treatment
☐ Independent Living	☐ Professional Foster Care	☐ Intensive Residential Treatment
☐ Crisis Stabilization	☐ Therapeutic Emergency Foster Care	
☐ Respite Care	☐ Group Care-Short Term (30-120 days)	
☐ Community Reintegration	☐ Group Care-Long Term (6-12 months)	

Has the Child been reviewed by the State Review Team (SRT)? Yes ☐ No ☐

Date that placement is needed:

Tribal Information

Tribe: Enrollment Number:

Family Services Specialist

Name: Office: Supervisor:

Email Address: Work Phone Number: Fax Number:

Juvenile Corrections Agent

Name: **Office:** **Supervisor:**

Email Address: **Work Phone Number:** **Fax Number:**

Parent/Guardian & Emergency Numbers:

Name	Relation to Student	Contact Approved	Monitored
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐

Person Juvenile has been living with or Emergency Contact:	Emergency Phone Number:

Group/Residential Referral Application (Continued)

Siblings		
NAME	**Age**	**Address**

No Contact List	
NAME	**RELATION TO YOUTH**

Materials to be Included

- ☐ Removal/Commitment Order giving Custody to the State
- ☐ Latest Report to the Court
- ☐ Initial Family Assessment or Juvenile Offender Intake Summary
- ☐ Copy of the Social Security Card
- ☐ Copy of Birth Certificate
- ☐ Copy of Most Recent Psychiatric Evaluation
- ☐ Copy of Most Recent Psychological Evaluation
- ☐ Copy of Discharge Summaries from Prior Placements
- ☐ Juvenile Living Guide Receipts – Juvenile & Parent (DOC only)

School Records

☐ Current IEP Current Grade Level: IQ Score (if available):

☐ Report Cards

☐ Other Services Provided

- ☐ Speech
- ☐ Language
- ☐ Counseling by School
- ☐ Behavior Issues

Group/Residential Referral Application (Continued)

Medical Records

☐ EPSDT, Immunization Records, TB Test, Dental, Vision, Hearing

Dates of Last:		
	TB Test:	Dental Visit:
	Vision Test:	Hearing Test:
	Physical Exam:	

☐ **List Allergies:**

☐ **Current Medications:**

☐ **Name & Phone Number of:**

Child's Doctor: Telephone:
Child's Dentist: Telephone:

Placement History

Name of Facility	Dates of Service	Completed Successfully
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐

☐ **Abuse & Neglect History:**

☐ **Drug / Alcohol History:**

☐ Child:

☐ Parents:

☐ **Fetal Alcohol Spectrum Disorder Information:**

☐ **Behaviors**					
Aggression	☐ Yes ☐ No	Sexual Abuse	☐ Yes ☐ No	Sexual Behaviors	☐ Yes ☐ No
Fire Starter	☐ Yes ☐ No	Suicidal Ideation	☐ Yes ☐ No	Self Harm	☐ Yes ☐ No
Run Away	☐ Yes ☐ No	Huffing	☐ Yes ☐ No	Drug Use	☐ Yes ☐ No
Alcohol Use	☐ Yes ☐ No	Car Theft	☐ Yes ☐ No	Sexually Active	☐ Yes ☐ No

If Sexual Behaviors Category is marked "yes":
Was sexual offender treatment recommended, and if so, has the child completed? ☐ Yes ☐ No

If yes, where was sexual offender treatment completed at?

☐ **Please list any other behaviors that the child may need services for:**

☐ **Please describe or give examples of each item checked "Yes" or listed as other:**

Additional information that would be helpful to know to provide appropriate care for the child:

Group/Residential Referral Application (Continued)

Reasons for Placement / Desired Treatment Outcomes:

Discharge Plan. Please indicate, in as much detail as possible, what the discharge plan is for the youth upon completion of this program:

Have Parents/Immediate Family been notified of this possible placement? Yes ☐ No ☐

If "No", please explain:

In order to maintain safety and security within the facility it may be necessary to utilize seclusion and/or restrain at times. The guidelines for the use of seclusion/restraint are enforced through licensing regulations.
Is the use of seclusion and restraint approved for this referral? Yes ☐ No ☐

Name of Person Completing This Form: **Date:**

SOUTH DAKOTA PRTF REFERRAL FORM
PSYCHIATRIC SERVICES UNDER 21

Please return the application and supporting documentation to the following address: Auxiliary Placement Program, Department of Social Services, 700 Governors Drive, Pierre, SD 57501-2291; or Fax # 605-773-7183; If you have questions, please call the Auxiliary Placement Program @ 605-773-3448.

A. IDENTIFYING INFORMATION

Child's Name: Date of Birth: Date submitted:

Gender: Male ☐; Female ☐; Medicaid eligible: Yes ☐; No ☐ Medicaid #:

B. CHILD'S CURRENT LIVING ARRANGEMENTS (Check the appropriate box and list name of facility/center/hospital)

☐ Parent/relative/non-relative
☐ Foster home
☐ JDC
☐ Group care center
☐ Residential treatment facility
☐ Acute Hospital

C. COMPLETE THIS SECTION IF REFERRAL IS BEING MADE BY DSS CPS, DOC OR TRIBAL/BIA AGENCY

Referring party: DOC ☒; CPS ☐; BIA/Tribal agency ☐ (identify agency)

Referring party contact information: Name:

Address: City: Zip:

Phone: Fax: E-mail:

Has the child received a GED**: Yes ☐; No ☐** Has the child received a Diploma: **Yes ☐; No ☐**

****TRIBAL or BIA AGENCY REFERRAL – COMPLETE THE FOLLOWING QUESTIONS**
Name of school district where child is currently enrolled:
TUITION TO BE PAID BY:
Is the child on an IEP: Yes☐; No☐; Currently being tested for IEP ☐; Primary IEP disability:

D. COMPLETE THIS SECTION IF REFERRAL IS BEING MADE BY A PRIVATE PARTY

Referring party: Parent ☐; School ☐; Mental Health Therapist ☐; Hospital ☐; Court Svc ☐; HSC ☐; Other ☐;

Referring party contact information:

Phone: Fax: E-mail:

Name of school district where child is currently enrolled:

TUITION: Is the child's school district agreeing to pay the tuition: Yes ☐; No ☐; Contacting school ☐;
Is the child on an IEP: Yes☐; No☐; Currently being tested☐; Primary IEP disability:
Has the child received a GED: Yes ☐; No☐ Has the child received a Diploma: Yes ☐; No☐

****If referral is being submitted by someone other than the parent / guardian please complete the following:**

Parent Name

Home Phone: **Work phone:** **Cell phone:**

Parent Address:

Parent / Guardian e-mail:

E. FACILITY BEING REQUESTED

Name of facility:

Has the facility accepted the child? Yes ☐; No ☐; Still reviewing ☐; Comment

List all other facilities you have contacted for potential admission and their responses:

F. PRIOR OUT OF HOME PLACEMENTS: Yes ☐; No ☐; TO INCLUDE: Psychiatric hospital; Human Services Center (HSC), residential treatment facility or group care center: If yes: list facility name, admit/discharge dates and outcome:

_____

G. PRIOR COMMUNITY BASED MENTAL HEALTH TREATMENT Yes ☐; No ☐;

If yes list name and timelines of treatment:

If no explain reason community-based treatment has not been attempted:

H. MOST CURRENT PSYCHOLOGICAL / PSYCHIATRIC EVALUATION:

Please request that the evaluation be submitted for review.

Evaluation completed by: Date

DSM – V Diagnosis:

Psychiatric Medications:

Full Scale IQ:

I. CURRENT BEHAVIORS WITHIN THE LAST 30 DAYS:

J. BEHAVIOR HISTORY INDICATING TIMELINES:

I acknowledge this referral is for a determination if the child meets criteria for placement in a Psychiatric Residential Treatment Facility governed by ARSD 67:16:47. Completion of this form is not a guarantee of service or placement nor is it a commitment on my part to place my child.

_____

Parent / Guardian Signature **Date**

STATE OF SOUTH DAKOTA
DEPARTMENT OF CORRECTIONS
DIVISION OF JUVENILE CORRECTIONS

Initial Status Report
RE:
DOC commitment date:

Dear Judge _____:

Enclosed please find the Juvenile Offender Intake Summary for_____, who was committed to the Department of Corrections on MM/DD/YYYY. This will serve as the first month's progress report.

<Enter Additional Comments Here>

Sincerely,

_____
Juvenile Corrections Agent

Enclosure: Juvenile Offender Intake Summary

DEPARTMENT OF CORRECTIONS
DIVISION OF JUVENILE CORRECTIONS

CONSENT FOR RELEASE OF INFORMATION

I, (Juvenile name) hereby consent to communication concerning me between , (Facility) and (JCA).

The purpose of this communication and disclosure is to share information about me between the agencies and individuals listed above for treatment planning purposes. The need for this disclosure is based upon the fact that I have been committed to the Department of Corrections and am under the guardianship of the secretary of corrections. The extent of information to be disclosed includes information concerning my activities and services received; assessment or test results. Including any diagnoses identified and any currently prescribed medication(s); information about my attendance or lack of attendance at school, evaluation or treatment sessions and my progress; my cooperation with the treatment program or services; and my prognosis.
The consent for release of information includes the sharing of written records including:

I understand that this consent will remain in effect and cannot be revoked by me until:

☐ There has been a formal and effective discharge from Department of Corrections jurisdiction.

☐ (other time when consent can be revoked)

☐ (other expiration of consent)

I understand that this information may be shared with other representatives of the Department of Corrections who have legitimate interest in this information.

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may redisclose it only in connection with their official duties.

Witnessed by	Juvenile's signature
Date witnessed	Date signed