

# *ASPEN RANCH*

a division of  
Aspen Education Group

## **APPLICATION FORM**

**Please include copies of all current school records, and transcripts of credits with the application packet. We need these to develop a Student Education History and Plan.**

**Aspen Ranch  
P.O. Box 500  
2000 West Dry Valley Road  
Loa, Utah 84747  
(877) 231-0734  
(435) 836-2278  
Fax (435) 836-2277  
[www.aspenranch.com](http://www.aspenranch.com)**

**ASPEN EDUCATION GROUP  
ASPEN RANCH  
PARENT "TO DO" CHECKLIST**

1. Contact your current clinician (Psychiatrist, psychologist, or therapist). Let your clinician know you are interested in placing your child in the Aspen Ranch program. Sign a "release of information" form so your clinician can discuss your child's case with your admissions counselor.
2. If your child has had any previous hospitalizations, contact the hospital's medical records department to have them fax/mail a copy of the medical record to your admissions counselor. Have them send any psych testing, psychiatric evaluations, history and physical, immunization records, etc.
3. Thoroughly complete the enrollment application and fax/mail back to your admissions counselor at least two business days prior to your anticipated admission date. Admissions are scheduled for Monday thru Friday at no charge. Emergency admissions may be accepted at any time.
4. \_\_\_\_\_ Include a copy of your child's immunization record  
\_\_\_\_\_ List any current and past medications  
\_\_\_\_\_ Send a copy of the student's insurance card (front and back)  
\_\_\_\_\_ **Include copies of all current school records, and transcripts of credits and IEP if applicable**  
\_\_\_\_\_ Sign the Power of Attorney form  
\_\_\_\_\_ Indicate your home family therapist on the Continuum of Care Agreement and the Release of Information  
\_\_\_\_\_ Include a recent photograph of your child  
\_\_\_\_\_ For divorced or separated parents, send a copy of the court custody agreements
4. Consult with your admissions counselor to arrange a date for your child to arrive in Utah.
5. Your admissions counselor will send you an individualized enrollment agreement. Please sign and fax/mail back the 2 signature pages to your admissions counselor to be received at least one day prior to your child's arrival in Utah. Mail your original signed enrollment agreement to your admissions counselor.
6. Please send your payment of \$18,715.00 made out to "Aspen Ranch" for the following:
  - a. First month's tuition of \$7,982.50
  - b. Transitional Service fee of \$7,982.50 for 1 year service beginning upon student's discharge.
  - c. Enrollment fee of \$2,750.00. The enrollment fee includes initial psychiatric evaluation, mental status exam, physical and lab work, and initial student gear which includes clothing.
7. Be certain to send a 30-day supply of any prescription medications. If you child is flying unattended; please send medication overnight. **DO NOT SEND MEDICATION WITH CHILD.**

**ASPEN RANCH  
STUDENT NEEDS LIST  
PROVIDED BY PARENTS**

Please send only what is on this list. If you are unable to get everything before your child leaves, you may mail it later.

30 day supply of medications currently being used – This needs to be accompanied by a note from the student's physician listing all medications and the frequency and dosage.

1 Twin size comforter for twin size bed.

Sleeping Bag

Athletic Shoes

**STUDENT CLOTHING/NEEDS LIST**  
**PROVIDED BY ASPEN RANCH**

Student Name \_\_\_\_\_

**List of clothing provided by Aspen Ranch upon admission**

- |                            |                                    |
|----------------------------|------------------------------------|
| 1. One comb or brush       | 18. 8 pairs of underwear size_____ |
| 2. One deodorant           | 19. 3 T-shirts size_____           |
| 3. One toothbrush          | 20. One sweatshirt size_____       |
| 4. One tube of toothpaste  | 21. One pair sweatpants size_____  |
| 5. One laundry bag         | 22. Two pair of jeans size _____   |
| 6. One sheet set           | 23. 1 set twin sheets              |
| 7. One pillow              |                                    |
| 8. One tube of lip balm    |                                    |
| 9. One pair of work gloves |                                    |
| 10. One water bottle       |                                    |
| 11. One journal            |                                    |
| 12. One towel              |                                    |
| 13. One washcloth          |                                    |
| 14. 8 pairs of socks       |                                    |
| 15. 1 pkg. Q-tips          |                                    |
| 16. 1 pair shower shoes    |                                    |
| 17. Belt                   |                                    |

Winter only:

1. One pair of thermal underwear size\_\_\_\_\_
2. One stocking cap
3. One coat size\_\_\_\_\_

Girls Only:

1. Two sports bras size\_\_\_\_\_
2. One package tampons or pads

After Round up:

1. (2) pair Khaki pants size\_\_\_\_\_
2. (3) Polo shirts size\_\_\_\_\_

**Please list the sizes your student takes so their clothing will be ready upon arrival.**



Aspen Education Group

ASSIGNMENT OF INSURANCE BENEFITS

PATIENT NAME: \_\_\_\_\_ ADMIT DATE: \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

ADDRESS OF INSURANCE COMPANY \_\_\_\_\_

TELEPHONE NUMBER OF INSURANCE COMPANY \_\_\_\_\_

GROUP # \_\_\_\_\_ POLICY \_\_\_\_\_

INSURED NAME \_\_\_\_\_ INSURED SS# \_\_\_\_\_

INSURED DATE OF BIRTH \_\_\_\_\_ RX Bin #(from ins card) \_\_\_\_\_

INSURED EMPLOYER \_\_\_\_\_

For the purpose of paying all or part of monies owing to ASPEN EDUCATION GROUP for services it has or will render to the above patient, the undersigned hereby irrevocably assigns to ASPEN EDUCATION GROUP any benefit payments payable for the benefit of said patient by the above insurance company or companies and all rights and interest in said policy but only to the extent necessary to pay ASPEN EDUCATION GROUP in full. Undersigned hereby grants to ASPEN EDUCATION GROUP the right to bill the above insurance company at retail or at the contract rate. Undersigned acknowledges and agrees, however, that ASPEN EDUCATION GROUP is not obligated or required to bill the insurance company, and may choose to bill the undersigned directly notwithstanding any insurance coverage that may exist. Undersigned agrees to remain liable to pay the full amount of all monies billed by ASPEN EDUCATION GROUP as a result of rendering services to the above mentioned patient and undersigned's liability will only be reduced by the amount of benefit payments received by ASPEN EDUCATION GROUP from the above referenced insurer. Notwithstanding the above, undersigned's liability will not be reduced until ASPEN EDUCATION GROUP has collected its full retail or contract rate. Undersigned understands that the nature of patient's disability may be such that no benefit payments will be payable under the policy specified above. ASPEN EDUCATION GROUP verifies insurance as a courtesy to the undersigned, and is not responsible for any misinformation received from the insurance company regarding benefits. It is the responsibility of the insured to understand his/her benefits and allowable coverage under the policy. ASPEN EDUCATION may bill the insurance company as a courtesy only. To the extent necessary to determine liability for payment and to obtain reimbursement, the undersigned authorizes ASPEN EDUCATION to disclose information from the treatment received to persons or corporations that may be liable for all or any portion of the facility's charges, including but not limited to insurance companies, health plans and Workers' Compensation carriers. Such information may include psychiatric evaluations, diagnoses, history and physical examination reports, program notes, physicians' orders and laboratory results, as well as school information. Such records may contain psychiatric or substance abuse information. Any monies owing by the undersigned under the terms of this Agreement shall be paid in full within thirty (30) days after billing by ASPEN EDUCATION GROUP unless other arrangements have been made. In the event that collection efforts are undertaken by ASPEN EDUCATION GROUP to enforce any of the terms of this Agreement, all expenses associated therewith, including attorneys' fees, will be paid by the undersigned. The undersigned acknowledges that he or she is entitled to receive a copy of this assignment/authorization.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
POLICY HOLDER AND/OR PARENT

**Please attach a photocopy of the student's medical insurance card in case of necessity.**

**ASPEN RANCH  
PSYCHIATRIC PROVIDER SELECTION FORM**

Student Name: \_\_\_\_\_

Date: \_\_\_\_\_

Parent Name(s): \_\_\_\_\_

Your student has two options for psychiatric care at Aspen Ranch. We ask that you make an initial choice based on your understanding of your child's psychiatric needs at the time of admission; however, your assigned therapist may recommend a change of provider after becoming more familiar with your child's psychiatric presentation and needs. The following outlines your choices with the associated benefits and drawbacks of each.

**Choice #1: Dr. Dean Belnap, Psychiatrist**

Benefits:

- 40+ years experience in psychiatric care
- Available to parents and therapists for communication and consultation
- Willing to consult with previous psychiatric providers
- Wants parental input before making treatment recommendations
- Extensive experience with adolescent programs
- Present at Aspen Ranch two days per month
- Spends significant time with each patient

Drawbacks:

- Visits cost \$120 and must be paid in advance of service delivery
- Insurance reimbursement may be difficult to obtain

**Choice #2: Sherree Rechtsteiner, FNP**

Benefits:

- Highly experienced and qualified Family Nurse Practitioner
- Consults with Dr. Belknap when additional insight or information may be needed
- Experienced in general psychiatric medication management
- At Aspen Ranch weekly for routine medical appointments
- Readily available for consultation with parents and therapists via telephone or email

Drawbacks:

- Less skilled for treating psychiatrically complex students
- Accepts a limited case load

I/we have been advised of the benefits and drawbacks associated with each psychiatric provider at Aspen Ranch and make the following choice selection with the understanding that my/our primary Ranch therapist may recommend a change in providers as my child's needs require. I/we also understand that while my/our choice is not final, I/we may not be permitted to switch back and forth between providers unless clinically necessary.

I/we elect to utilize the following psychiatric provider for my/our child at Aspen Ranch.

*(Initial your choice)*

\_\_\_\_\_ Dr. Dean Belnap, MD

\_\_\_\_\_ Sherree Rechtsteiner, FNP

\_\_\_\_\_  
Parent signature

\_\_\_\_\_  
Parent Signature

# POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENT, that I/we \_\_\_\_\_ (the parent(s)/legal guardian(s) and hereafter known as the "Sponsor"), do hereby certify to Aspen Education Group, which owns and operates the program known as Aspen Achievement Academy and Aspen Ranch, that I/we are the true and lawful attorney in-fact and legal custodian(s) for \_\_\_\_\_, (hereinafter the "Student"), and said student is my/our \_\_\_\_\_. Student was born on \_\_\_\_\_. We hereby execute this Power of Attorney for the purpose of providing custodial care, educational, therapeutic and clinical services in connection with the Aspen Achievement Academy and/or Aspen Ranch Program (hereinafter known as the "Program").

Without limiting or qualifying the general Power of Attorney granted and delegated by Sponsor to Aspen in the paragraph above, Sponsor specifically grants to Aspen the following powers:

1. To provide or obtain all medical, dental, psychiatric treatment and hospital care, and to authorize a physician to perform any and all procedures that may appear to be medically necessary for the well being of the Student;
2. To guide and discipline the Student as deemed necessary and reasonable by Aspen (but not to include physical punishment);
3. To physically restrain the Student should he/she become a danger to himself/herself or to anyone else, as deemed necessary by Aspen;
4. To allow the Student to participate in all activities that may risk physical injury or illness, as outlined in Aspen's Enrollment Agreement and Program Description, and
5. To search the person and personal effects of the Student at any time as Aspen Education Group in its discretion deems appropriate, and seize and confiscate any items deemed by Aspen to be contraband or counterproductive to the Student's successful completion of the Program. The search of the Student's person may require Student to remove all of his or her clothing and may include a "strip search" of all or any portions of Student's body, including cavities in which contraband could be hidden.
6. To restrict the Student's access to telephone calls, visitors and delivered materials.

This Power of Attorney shall be effective from date of arrival, beginning \_\_\_\_\_, 20 \_\_\_\_ and ending upon the Student's completion of the Program, unless terminated by Sponsor by withdrawing the Student from the Program prior thereto.

I/We have executed this Power of Attorney on this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

I/We declare under penalty of perjury that the foregoing is true and correct.

\_\_\_\_\_  
Signature of Sponsor  
(Father/Guardian)

\_\_\_\_\_  
Signature of Sponsor  
(Mother/Guardian)

\_\_\_\_\_  
Home Address

\_\_\_\_\_  
Home Address

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Driver's License Number

\_\_\_\_\_  
Driver's License Number

\_\_\_\_\_  
Notarized by

\_\_\_\_\_  
Date

**VOLUNTARY PATIENT CONSENT TO RECEIVE PSYCHOACTIVE MEDICATIONS**

TO \_\_\_\_\_  
Name Of Patient

Your attending physician is \_\_\_\_\_ M.D.

State Department of Mental Health regulations require the treatment center to maintain a written record of your decision to consent to the administration of psychoactive medications. You may be treated with psychoactive medication only after you have been informed of your right to accept or refuse such medications and have consented to the administration of such medications. In order to make an informed decision; the physician prescribing such medications, which shall include the following, must provide you with sufficient information;

The nature of your mental condition

The reasons for your taking the medication, including the likelihood of your improving or not improving without the REASONABLE ALTERNATIVE TREATMENTS AVAILABLE. IF ANY: the TYPE, range of frequency and amount (including use of PRN orders), method (oral or injection), and duration of the probable side effects of these drugs known to commonly occur, any particular side effects likely to occur, and the possible additional side effects which may occur if you take such medication beyond three months. You should have been advised that such effects may include persistent involuntary movement of the face or mouth at times, and include similar movement of the hands and feet after medications have been discontinued.

Your signature below constitutes your acknowledgment: 1) that you have read and agree to the foregoing; 2) that the medications and treatment set forth below have been adequately explained and/or discussed with you by your supervising physician, and that you have received all of the information you desire concerning such medication and treatment; and 3) that you authorize and consent to the administration of such medication.

Medication and Treatment

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

Signature \_\_\_\_\_  
Patient/Parent/Legal Guardian (Please circle)

\_\_\_\_\_  
Time

If signed other than patient, indicate relationship

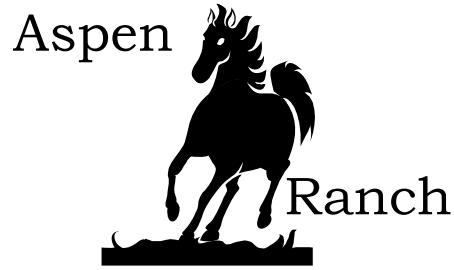
\_\_\_\_\_  
Witness

\_\_\_\_\_

Notations by Physician (if applicable) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





### Authorization for Excursion

I hereby consent to have my child participate in walks or field trips, by car or van, supervised by the school staff, away from school grounds to nearby points of interest.

An administrative decision to continue or to cancel will be made prior to taking a scheduled field trip.

\_\_\_\_\_ Yes, my child has my permission to go on field trips

\_\_\_\_\_ No, my child may not attend field trips and is to remain at school in an alternative curriculum experience for the day.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature (Parent or Legal Guardian)

### Parental Consent for Curriculum Experience of Minors

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Permanent Address: \_\_\_\_\_

\_\_\_\_\_

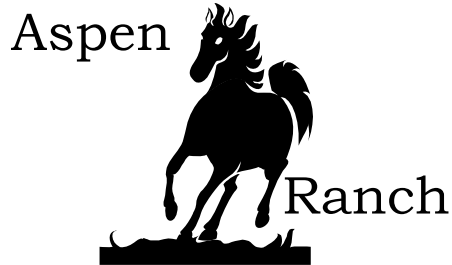
I hereby give permission for my son/daughter to work in any agricultural/farm occupation **NOT** declared hazardous by the Secretary of Labor.

\_\_\_\_\_

Parent or Guardian Signature

\_\_\_\_\_

Date



**Authorization for Emergency Medical Services**

Name of child: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Age: \_\_\_\_ years \_\_\_\_ months Sex: \_\_\_\_ Grade in Fall: \_\_\_\_\_  
 Parents' (or legal guardian) Name: \_\_\_\_ Mother Father  
 Work Phone: (\_\_\_\_) \_\_\_\_\_ Hours at work: \_\_\_\_ to \_\_\_\_ (\_\_\_\_)  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ Pager: (\_\_\_\_) \_\_\_\_\_ Cellular: (\_\_\_\_) \_\_\_\_\_

Give the name of two (2) other persons who may be called in an emergency, if the above person cannot be reached:

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_
2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Physician (to be called in an emergency): \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_\_ Hospital Preference: \_\_\_\_\_  
 Counselor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Allergic to: \_\_\_\_\_

Has your child ever had a seizure? If yes, explain type and conditions: \_\_\_\_\_  
 \_\_\_\_\_

Special needs: \_\_\_\_\_

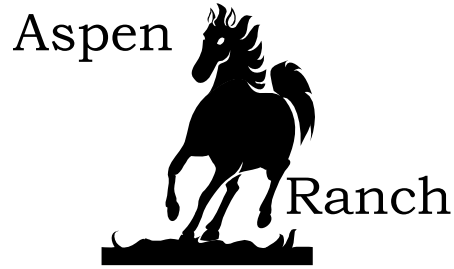
I hereby authorize Aspen Ranch School to call an emergency ambulance in case of an accident or acute illness and to arrange for necessary emergency medical or surgical care in case I am not immediately available.

It is understood that a conscientious effort will be made to notify me or the persons designated before such action will be taken.

I also hereby agree to accept responsibility for the cost of the above medical services. I have provided the school with a photocopy of my child's insurance card.

\_\_\_\_\_  
 Date Signature (parent or legal guardian)

Persons authorized to pick up child:  
 Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_



## Authorization to Release and/or Request Information

Date of Request: \_\_\_\_\_

Name of Student: \_\_\_\_\_

### Type of information:

\_\_\_\_\_ Speech/Language Report  
\_\_\_\_\_ Medical  
\_\_\_\_\_ Psychological  
\_\_\_\_\_ Drug/Alcohol

\_\_\_\_\_ Educational  
\_\_\_\_\_ I.E.P.  
\_\_\_\_\_ Other: \_\_\_\_\_

### Release of information to/from:

Aspen Ranch School  
2000 West Dry Valley  
P.O. Box 369  
Loa, UT 84747  
FAX: 435 836-2277

### Release of information from/to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Attn: \_\_\_\_\_

Authorization is not required for the exchange of report cards, transcripts and attendance records between schools.

I understand that requester may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

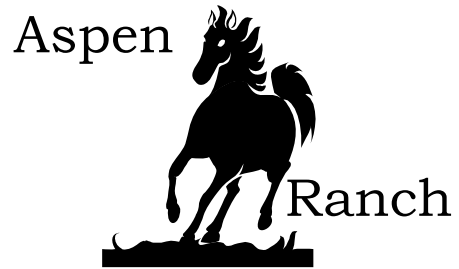
I understand that I have the right to receive a copy of this authorization if I so request.

I hereby authorize release of the above specified information.

Printed name of Parent/Guardian: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Date



I hereby give permission for \_\_\_\_\_ to be photographed by Aspen Ranch staff. I further authorize Aspen Ranch to use said photographs in connection with location and return of students who have left the facility without authorization.

Printed Name: \_\_\_\_\_

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_



I \_\_\_\_\_ hereby acknowledge that I have  
received a copy of the Aspen Ranch Parent Handbook.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



# Aspen Ranch

## PARENT RIGHTS

- You and your child have the right to be treated with respect.
- You have the right to be informed about your child’s care and treatment including risks, side effects, and benefits of all medications and treatment procedures.
- You have the right to request the opinion of a consultant, at your expense.
- You have the right to have all information concerning your child’s treatment be confidential according to state and federal guidelines.
- You have the right to know this is not a locked facility. Staff makes every effort to prevent students from running away, but it may happen.
- You have the right to receive a Parent Handbook including rules of the center.
- You have the right to send and receive private, unopened, uncensored mail to and from your child.
- You have the right to know that if a child is a danger to him/herself or others, PCS physical restraints may be used by trained staff.
- You have the right to appeal level changes or discipline without repercussion or retribution.
- You have the right to communicate and visit according to rules of The Ranch.

If you feel you have been denied any of these rights or that quality of services has been less than standard or that discipline or level drops were inappropriate, you have the right to present your concerns by written notice to:

**Program Administrator**  
**Aspen Ranch**  
**P.O. Box 369**  
**Loa, UT 84747**

An attempt to resolve the difference will be made by the program administrator and you will receive a written answer within 5 working days.

- If you believe your concerns are not adequately resolved via the Program Administrator, you have the right to appeal to the Regional Director, Robin Stephens. If you believe your concerns are not resolved by the Regional Director, you have the right to appeal to the CRC Consumer Affairs office. Contact information for any and all of these people is available by contacting Aspen Ranch. Your child has the same rights and a copy of these rights are contained in the student handbook.

No punitive action will be taken by the Ranch toward anyone submitting a concern.

Client Name: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_





## Medication Policies and Procedures

The Aspen Ranch Medical Director and Medical Provider oversee all medications administered at Aspen Ranch. Unfortunately, we are unable to fill new prescriptions from family physicians after treatment has begun. During your child's stay at the Ranch, we will only administer medications prescribed or approved by the above providers. In the event of a medication change, the medical staff will seek approval from the primary guardian prior to initiating the requisition.

### **Prescriptions:**

Aspen Ranch requires that you send a minimum 2 week supply of current prescription medications with your child when they enter the facility. It would be helpful if you include the name of the medication, current dosage, and administration times.

All prescriptions are filled through Lin's Pharmacy and the Wayne Community Health Center Pharmacy. Both pharmacies accept most insurance policies. Your credit card will automatically be billed for the co-pay amount. In the event that prescription coverage has lapsed, your credit card will be charged the retail price. It is important that you completely fill out **ALL** the information on the Lin's Pharmacy and Wayne Community Health Center billing forms, including your credit card number and signature, even if your student does not currently have a prescription.

If your insurance requires the use of a mail-order pharmacy for on-going prescriptions, every effort will be made to accommodate this request. Please note that new medications and prescriptions that are required immediately (such as antibiotics) will be filled through the pharmacies listed above. Subsequent refills may be requested through mail-order. Please ensure that the Aspen Ranch Medical Office has all current medical, prescription and dental policy information. Quality treatment does not permit us to allow an interruption in medication administration due to insurance coverage complications.

### **Vitamins and Supplements:**

If the medical or psychiatric provider recommends any vitamins or supplements, they will be obtained from our local pharmacy after parent approval. Please do not send vitamins, diet medications, or metabolic or growth stimulators from home. *They will be returned.*

### **Over-the-Counter (OTC) Medication:**

**In addition to the prescription medication I have sent for my child, I give permission for my child to have the following over-the-counter remedies on an as-needed basis with the exception for allergies and contraindications. OTC remedies are obtained only from the medical dept. or trained personnel. These include but are not limited to:**

- Pain Relievers: Advil (Ibuprofen), Tylenol (Acetaminophen), Bengay (or other topical analgesic)
- Stomach/GI Upset: Imodium (Loperamide), Milk of Magnesia, Maalox, Tums, Pepto-Bismal (Bismuth)
- Allergies: Sudafed (Phenylephrine), Mucinex (Guaifenesin), Benadryl (Diphenhydramine), Claritin (Loratidine)
- Skin Irritations: Cortaid (Hydrocortisone cream), Athlete's Foot cream/powder, Aloe Vera gel

We appreciate your cooperation and look forward to working with you and your student during their stay at Aspen Ranch. If you have any questions regarding the above policies, we invite you to call our medical department at 435-836-1107, or e-mail [nurses@theaspenranch.com](mailto:nurses@theaspenranch.com).

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

## ASPEN RANCH ENROLLMENT AGREEMENT

This agreement ("Agreement") is entered into by and between Aspen Ranch, a Delaware limited liability company (hereinafter "Aspen"), operating Aspen Ranch, a licensed residential program, which is described in the program materials that Sponsor has received previously and which is made a part of this Agreement by reference (the "Program") and **Parents' Name:** \_\_\_\_\_ parent(s) and /or guardian(s) of the student (herein after the "Sponsors") **Parents' Address:** \_\_\_\_\_ and **Phone Number:** \_\_\_\_\_.

In consideration of the mutual promises set forth in this Agreement, Aspen and Sponsor (hereinafter the "Parties") mutually agree as follows:

1. **SPONSOR'S REPRESENTATIONS.** Sponsor warrants that Sponsor is the legal parent(s) and/or guardian(s), having legal custody, of the following child:

**Student Name:** \_\_\_\_\_ (full and preferred name), whose birth date is

**Date of Birth:** \_\_\_\_\_ (hereinafter the "Student"), and that Sponsor desires to and does hereby contract with Aspen for the Student's enrollment in the Program according to the terms and conditions of this Agreement. In entering into and performing under this Agreement, Aspen is relying on all representations and promises of the Sponsor contained or expressed in this Agreement and all other documents and information sheets from Sponsor to Aspen, and Sponsor expressly warrants the truth and accuracy of the same.

2. **ENROLLMENT OF THE STUDENT.** Upon Sponsor's initial payment as set forth in Exhibit "A", and completion of this Agreement, the Enrollment Application and all related documentation, and upon Aspen's execution of this Agreement, Aspen shall accept the Student conditionally for enrollment in the Program, subject to the terms and conditions of this Agreement. Sponsor acknowledges and agrees that Aspen's conditional acceptance of the Student is subject to the personal evaluation and screening process conducted by Aspen prior to completion of the Assessment phase of the Program. If the Student satisfies Aspen's screening criteria, Aspen shall accept the Student and, except as otherwise provided herein, permit the Student to complete the Program. If the Student fails to satisfy Aspen's screening criteria, the Student will be returned promptly to Sponsor and Aspen will also return the prepaid tuition fee to the Sponsor, less a \$750.00 evaluation/screening fee and a deduction for all reasonable expenses incurred by Aspen on behalf of the Student and/or the Sponsor prior to the Student's return.

3. **TERM OF AGREEMENT/CUSTODY.** Assuming the Student is accepted into the Program, the term of this Agreement shall be a minimum of **Nine Months** beginning with the Student's arrival in Salt Lake City, Provo, or Loa, Utah, as the case may be, now anticipated on **date of arrival:** \_\_\_\_\_ (the "Arrival Date"). On the Arrival Date, Sponsor shall transfer, by a Power of Attorney in the form received and executed by Sponsor, temporary custody of the Student to Aspen for the duration of the Agreement, unless either party terminates this Agreement prior thereto by giving written notice to the other party pursuant to paragraph 10 herein or until the Student attains the age of eighteen (18), unless the Student (a) has otherwise been placed in the custody of Aspen by a court of proper jurisdiction or (b) voluntarily consents in writing to remain in the Program for any period of time beyond said eighteenth (18th) birthday.

#### 4. **PROGRAM COSTS AND PAYMENT TERMS.**

A. **PROGRAM FEE.** The Student is accepted with the expectation that the Student will complete the entire Program. Unless otherwise set forth in Exhibit "A", the Program fee is: Three Hundred Fifty Dollars (\$350.00) per day for the Program, including therapy.

B. **FEE INCREASES.** The current tuition fee is subject to an annual increase effective January 1<sup>st</sup> each year. The program shall provide a 60-day notice detailing the amount of the increase.

#### C. **SCHEDULE AND METHOD OF PAYMENT OF PROGRAM FEES; LATE FEES.**

(1) At the time of admission, private pay sponsors shall pay an initial payment which consists of one month's tuition, the enrollment fee, plus the alumni fee. This initial payment may be paid by check.

(2) With the exception of pre-paid quarterly and annual tuition payments, all subsequent payments shall be paid only by accepted credit card (VISA, Mastercard or American Express), wire transfer or pre-authorized electronic check debits (ACH). Sponsor shall receive a 5% discount on pre-paid annual tuition payments. Unlike other payment methods, Sponsor may elect to pre-pay quarterly and annual tuition payments by check.

(3) Sponsor shall also provide a valid credit card number with a credit capacity equal to two months' tuition at the time of admission. In the event that a subsequent tuition payment is not paid when due, Sponsor authorizes the program to charge the past due amount, including late fees, to the credit card number provided by the Sponsor at the time of enrollment.

(4) Payments are due the 1st day of the month of service. For example, October tuition is due October 1st. Payments not received by the 10<sup>th</sup> of the month of service are subject to a \$250 late fee and may result in discharge of the student from the program. With the exception of the discharge summary, transcripts and other transition information, such as student records, will not be released after a student discharges until all tuition and fees are paid in full.

(5) Students with student loans must provide a copy of an executed promissory note from the lending institution prior to enrollment. Actual funding must take place within five days of enrollment. Students receiving school district assistance must pay tuition and fees when due. The program will refund Sponsor upon receipt of payment from the school district.

(6) The program is not in a position to absorb delinquent private pay and or insurance balances. The program reserves the right to discharge students whose private pay or insurance claims become delinquent. Students with a contracted insurance provider must provide the program with pre-approval by the insurer at the time of admission. Sponsor shall pay the first month's co-pay and deductible at that time. If the contracted insurance provider fails to pay within 60 days of submission of a claim, Sponsor shall pay the amount due.

Students with a non-contracted insurance provider must provide the program with pre-approval by the insurer at the time of admission. Sponsor shall pay the enrollment fee and the first month's tuition at the time of admission. If the non-contracted insurance provider fails to pay within 60 days of submission of a claim, Sponsor shall pay the amount due. Sponsor will be timely refunded after the program receives insurance payments (excluding AB3632).

D. **PAYMENT/CANCELLATION REFUNDS.** A cancellation received less than seven (7) days prior to the arrival date will result in a 50% refund. If deemed appropriate by Aspen, the amount retained may be used as credit against any future enrollment of the Student.

E. **EARLY WITHDRAWAL OF STUDENT.** If Sponsor withdraws Student before expiration of the period of enrollment without the recommendations of the Executive Director, forfeiture of the **\$7,982.50** alumni fee will occur.

F. **ADDITIONAL COSTS AND EXPENSES.** In addition to the Program fee, Sponsor agrees to pay for the following expenses of the Student: transportation from the Student's current residence to Salt Lake City, Provo, or Loa, Utah, as the case may be, and return transportation to the Student's current residence; food and lodging expenses for any holding period before commencement of the Program and/or after completion of the Program; all medical, dental, hospital, and related expenses incurred by or for the Student and all required personal items specified in the Student Clothing List. Sponsors are also responsible for any additional fees such as off campus activity expenses, escort fees required for transporting Student to and/or from the Program to another location (i.e. airport, doctor's appointment or special event). Sponsors are responsible for the cost of any psychiatric evaluations performed by a psychiatrist.

G. **PERSONAL INJURY AND DAMAGE TO PROPERTY.** Sponsor agrees to accept full responsibility for (1) the repair or replacement of any property damaged, defaced, or destroyed by the Student, whether owned, leased, or controlled by Aspen or any third party, and (2) any personal injury to any Aspen personnel, other students or third parties caused, in whole or in part, by the Student; and to promptly reimburse Aspen for any costs and expenses, including legal fees, it may incur in connection therewith.

H. **RUNAWAY EXPENSES.** In the event the Student runs away from the Program, Aspen will make every reasonable effort to find the Student and return the Student to the Program or to the Sponsor. An accounting of the expenses incurred by Aspen in finding and returning the Student will be made to the Sponsor who agrees to accept full responsibility for any and all such costs and expenses, and to pay the same within seven (7) days of the Sponsor's receipt of said accounting.

I. **LOSS OR DAMAGE TO STUDENT'S PROPERTY.** Aspen is not liable for any loss of or damage to any of the Student's property. The Student is fully responsible for the same at all times.

J. **SUBCONTRACTING.** Sponsor agrees and consents to Aspen's subcontracting certain services to be rendered under this Agreement to persons or entities deemed by Aspen to be properly qualified to provide said services, at no additional cost to Sponsor unless otherwise agreed to by both parties. Aspen is not responsible for the services provided by such third-party contractors and is hereby released from any liability arising from such services. All clinicians furnishing services to the Student, including any psychiatrists, psychologists, mental health professionals, or internists or the like, are independent contractors with the client and are not employees of Aspen. The Student is under the care and supervision of his/her attending clinician and it is the responsibility of the Student's clinician to obtain the Sponsor's informed consent, when required, for medical, surgical, or psychiatric treatment, special diagnostic or therapeutic procedures, or other services rendered the Student under the general and special instructions of the clinician.

K. **NURSING CARE.** Aspen provides only general nursing care unless, upon orders of the Student's physician, the Student is provided more intensive nursing care. If the Student's condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by the Sponsors. Aspen shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that Student is not provided with such additional care.

5. **ASSUMPTION OF RISKS; RELEASES AND INDEMNITIES.** Sponsor acknowledges serious hazards and dangers, known and unknown, inherent in the Program, including but not limited to ranch, agricultural and vocational activities, emotional and physical injuries, illness or death that may arise from low physical impact and risk of physical injury, conducted in urban or metropolitan areas with ready access to medical and other emergency services. Museums, zoos, theaters, restaurants, golf courses, bowling alleys, community activities and service, arcades, shopping centers, historical sights, church attendance, picnics, livestock shows, county fairs, correctional facilities, schools, universities, national and state parks, spectator sporting events, 12 step meetings, medical appointments, softball, volleyball, basketball, high school rodeo events, penning, roping, barrel racing, strenuous hiking, climbing, rappelling, Questing, rock climbing, horse back riding, and camping in a natural environment, exposure to the elements, plants and animals, running away from the Program, "acts of God" (nature), the ropes course, kayaking, whitewater rafting, sail-boarding, snow skiing, swimming, fishing, mountain biking, water sports, stress involvement with other students, self-inflicted injuries, and transportation to and from the Program's field location(s). Sponsor understands that in participating in the Programs Student will be in locations and using facilities where many hazards exist and is aware of and appreciates the risks which may result. Sponsor understands that accidents occur during such activities due to the negligence of others which may result in death or serious injury. Sponsor and Student are voluntarily participating in the Programs with knowledge of the dangers involved and agree to accept any and all risks.

In consideration for being permitted to participate in the Programs, Sponsor agrees to not sue, to assume all risks and to release, hold harmless and indemnify Aspen and any and all of its predecessors, successors, officers, directors, trustees, insurers, employees, managers, agents, volunteers, community organizations, administrators, heirs, attorneys, executors, assigns and/or related or affiliated business entities including, but not limited to, Aspen Achievement Academy, Aspen Education Group and Aspen Ranch Residential Treatment Center (collectively all of the above persons and entities shall be referred to as the "Released Parties" hereafter) who, through negligence, carelessness or any other cause, might otherwise be liable to Sponsor or Student under theories of contract or tort law.

Sponsor intends by this Waiver and Release to release, in advance, and to waive his or her rights and discharge each and every one of the Released Parties, from any and all claims for damages for death, personal injury or property damage which Sponsor may have, or which may hereafter accrue as a result of Student's participation in any aspect of the Programs, even though that liability may arise from negligence

or carelessness on the part of the persons or entities being released, from dangerous or defective property or equipment owned, maintained or controlled by them or because of their possible liability without fault. Additionally, Sponsor covenants not to sue any of the Released Parties based upon their breach of any duty owed to Sponsor or Student as a result of their participation in any aspect of the Programs. Sponsor understands and agrees that this Waiver and Release is binding on his or her heirs, assigns and legal representatives and that the Released Parties shall be exempt from liability to Sponsor, his or her heirs, assigns and legal representatives.

Student is physically capable of participating in the Programs, and his or her medical care provider has approved his or her participation. If Sponsor is aware that Student is under treatment for any physical infirmity, ailment or illness, Student's medical care provider knows of and has approved Student's participation in the Programs. Sponsor acknowledges that Sponsor, and Sponsor alone, is solely responsible for Student's personal health and safety, and the personal property Student brings with him or her. Sponsor acknowledges that the medical insurance information Sponsor has provided on the Medical Form is current and complete and that Sponsor is solely responsible for procuring and maintaining all medical insurance Sponsor deems necessary and that the Released Parties have recommended that Sponsor procure and/or maintains medical insurance. Sponsor accepts full responsibility for any costs incurred for medical treatment due to failure to procure or maintain insurance, or providing outdated or falsified insurance information. Sponsor understands that it is ultimately Sponsor's responsibility to provide payment to any hospital/emergency response technicians/emergency transport company that may provide services to Student as a result of injury/illness during the Programs.

Sponsor agrees that this Release extends to all claims of every nature and kind whatsoever, and hereby expressly waives all rights under California Civil Code section 1542 which provides as follows:

**"A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor."**

Sponsor agrees to indemnify the Released Parties from any and all actions, causes of action, claims, demands, damages, costs (including attorneys' fees), expenses, liabilities and charges, known or unknown (the "Liabilities") arising out of or in connection with claims and/or actions relating to or brought by or on behalf of Student, including, without limitation, claims related to or arising out of the Minor's participation in the Program. **Initials:** \_\_\_\_\_.

**6. AUTHORIZATION FOR MEDICAL CARE AND RECORDS.** In the event of an accident, injury, illness, or other medical necessity, Sponsor hereby authorizes Aspen to: (a) provide emergency first aid to the Student in the field and en route to any hospital or clinic, (b) arrange for any medical, dental, psychiatric, hospital, ambulance or other health-related care for the Student deemed necessary by Aspen's staff; and (c) authorize a physician, dentist or other health-care professional(s) to perform any procedure(s) that the health-care professional(s) deems necessary for the well-being of the Student. All costs and expenses incurred for these services shall be the sole responsibility of the Sponsor. Sponsor also authorizes Aspen to arrange for a physical examination (including a drug screen urine/blood test, at Aspen's option) and any psychological assessments of the Student deemed necessary by Aspen prior to the Student's beginning the Program. Sponsor also authorizes any and all medical doctors, psychiatrists, psychologists, counselors, therapists, hospitals, clinics and treatment centers that have treated or counseled the Student, and whose names Sponsor shall provide to Aspen, to release all information regarding the Student's medical and/or psychological history, diagnoses and treatments to Aspen upon request. Sponsor shall provide to Aspen, to release all information regarding the Student's medical and/or psychological history, diagnoses and treatments to Aspen upon request. Aspen shall handle all such protected health information (also "PHI") pursuant to the guidelines promulgated in the Health Insurance Portability & Accountability Act ("HIPAA") of 1996.

**7. AUTHORIZATION FOR SEARCH AND SEIZURE.** Sponsor hereby authorizes Aspen personnel to search the person and personal effects of the Student at any time, including a "strip search." In connection with such search, Aspen may, in its discretion, require Student to remove all of his or her clothing and may search Student's entire person, including any body cavities in which contraband may be hidden. Aspen is further authorized to confiscate any and all items deemed by Aspen to be contraband or counterproductive to the Student's successful completion of the Program. The disposition of all items confiscated by Aspen shall be left to the sole discretion of Aspen.

**8. AUTHORIZATION FOR RESTRAINT.** Sponsor hereby authorizes Aspen personnel to physically restrain, control and detain the Student by the exercise of necessary restraints when deemed necessary by Aspen, for purposes including but not limited to escorting the Student to and from the Program's location, returning the Student to the Program if the Student runs away, or preventing the Student from jeopardizing the Student's own safety or the safety of others. In the event of a runaway, all appropriate law enforcement agencies or security personnel of any federal, state, county or municipal entity are hereby directed to detain and retain custody of the Student until Sponsor or any personnel of Aspen arrive, at which time Aspen personnel may re-obtain custody or control of the Student or authorize continued custody by the law enforcement agency until travel is arranged for the Student's return home.

**9. RESEARCH AUTHORIZATION.** Sponsor hereby authorizes Aspen to use data from the Student's records, tests, and assessments for purposes of ongoing research, provided that the Student's name and identity will be kept confidential and not used in any published materials.

**10. EARLY TERMINATION/LIQUIDATED DAMAGES.**

**A. TERMINATION BY ASPEN.** Aspen reserves the right to terminate this Agreement at any time due to: (i) failure of Sponsor to pay any amounts due under paragraph 4; (ii) illegal, uncontrollable, or dangerous behavior by the Student; (iii) discovery of any unprompted or previously unknown physical, medical, mental, or emotional problem(s) of the Student; or (iv) for any other reason if Aspen deems it necessary for the protection of the Student, any other student(s) or the integrity of Aspen's Program. In the event of any such

termination by Aspen after the Student has been accepted into the Program, neither Sponsor nor Student's insurer shall be entitled to a refund of any part of the Program fee or tuition. However, in the sole discretion of Aspen, except in the case of termination under paragraph 10A(i) above, the Student may participate in a subsequent Program if the condition(s) that led to the Student's prior termination has been resolved to Aspen's satisfaction, with a credit, to be determined by Aspen in its sole discretion, against the Program fee for prior Program fee payments.

**B. WITHDRAWAL BY SPONSOR.** In the event Sponsor or any authorized third party, after the Student's arrival date, withdraws the Student for any reason prior to the end of the Program, or if the Student decides to leave the Program after the Student's eighteenth birthday, neither Sponsor nor the Student's insurer shall be entitled to a refund of any part of the Program fee or tuition. However,

in the sole discretion of Aspen, the Student may participate in a subsequent program if the condition(s) that led to the Student's prior withdrawal has been resolved to Aspen's satisfaction, with some appropriate credit, to be determined by Aspen in its sole discretion, for prior Program fee payments.

**C. LIQUIDATED DAMAGES.** Aspen's entitlement to and retention of the entire Program fee payable under this Agreement in the event of an early termination or withdrawal is not considered by either of the Parties to be a penalty for early withdrawal of the Student. Because of Aspen's fixed costs, the impossibility of filling the Student's position once the Program is underway, and the difficulty of estimating and recovering Aspen's losses caused by the Student's early termination or withdrawal, the Parties agree that this non-refundable Program fee policy constitutes a fair and reasonable estimate of Aspen's losses (i.e., liquidated damages) associated with any early termination or withdrawal of the Student from the Program.

**11. SPONSOR EDUCATION PROGRAM AND COOPERATION.** Sponsor agrees to attend the seminar for parents and guardians of the students conducted by Aspen during the Program, and to give Sponsor's full cooperation to Aspen personnel throughout the Program, in order to maximize the benefits of the Program for the Student and the Sponsor. Sponsor also agrees to read any educational materials and watch any video programs sent to Sponsor by Aspen, and to fill out and return to Aspen any interactive educational materials, while the Student is in the Program.

**12. ESCORTS.** If an escort is required to bring the Student to Utah for the Program, Sponsor agrees that any escort or escort service used by Sponsor, whether or not Sponsor is referred to the escort by Aspen, is in all respects an independent contractor contracting directly with Sponsor. Sponsor agrees that Aspen bears no responsibility of any kind for any such escort service or the negligence or failure thereof.

**13. HEALTH INSURANCE.** Sponsor warrants that the Student is presently covered, and will for the duration of the Program be covered, by adequate health insurance covering claims that may arise in connection with any accident, injury or illness that the Student may suffer or incur during the Program. Whatever deductibles or coverage exclusions may apply in a given case shall be satisfied entirely by Sponsor.

**14. EMANCIPATION.** Sponsor warrants that the Student is a minor, both by age and as a matter of law, that the Student does not qualify under the law as an "emancipated minor," and that the laws of the Student's state of residence permit Sponsor to place the Student in the Program without the Student's consent.

**15. DELAYED PERFORMANCE.** Except for the obligation to make payments when due hereunder, all other obligations under this Agreement shall be suspended for so long as one or both Parties hereto are prevented from performing hereunder by acts of God/nature, the elements, acts of federal, state or local governments, agencies or courts, damage to or destruction or unavoidable shut-down of necessary facilities, or other matters beyond their reasonable control; provided, however, that any party so prevented from complying with its obligations hereunder shall promptly notify the other party thereof and shall exercise due diligence to remove and overcome the cause of such inability to perform as soon as practicable.

**16. BINDING ARBITRATION.** Any controversy or claim arising out of or relating to this contract, except at Aspen's option the collection of monies owed by Sponsor to Aspen, shall be settled by binding arbitration conducted in the State of Utah in accordance with the rules of the American Arbitration Association. Judgment upon the award rendered by the arbitrator(s) may be entered in any court of competent jurisdiction for purposes of executing upon the award.

**17. ATTORNEY'S FEES.** In the event that either party is found in default or material breach of any specific promise, term or condition expressly set forth in this Agreement by an arbitrator(s) or a court of competent jurisdiction, said party shall be liable to pay all reasonable attorneys' fee, court costs and other related collection costs and expenses incurred by the other party in enforcing its contractual rights hereunder in said arbitration and/or court proceeding(s). In addition, Sponsor agrees to compensate Aspen for all reasonable attorneys' fees and costs incurred by Aspen in connection with those matters concerning which Sponsor has agreed to pay or indemnify Aspen hereunder.

**18. NOTICES.** Any and all notices, payments, reports and other correspondence required hereunder shall be deemed to have been properly given or delivered when made in writing and delivered personally to the party to whom directed, or when sent by United States mail with all necessary postage or charges fully prepaid, and addressed to the party to whom directed at its below specified address (or a new address after written notice of such change is given to the other party).

**Aspen Ranch**  
**PO Box 369**  
**2000 West Dry Valley Rd**  
**Loa, UT. 84747**

**Parent's Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City, State, Zip Code:** \_\_\_\_\_

**19. AMENDMENTS.** This agreement may be amended at any time upon mutual agreement of the parties hereto, but any amendment(s) must first be reduced to writing and signed by both parties in order to become effective.



**EXHIBIT "A"**  
(Private Pay Tuition Agreement)

This Exhibit sets forth the payment terms of the Enrollment Agreement and is expressly incorporated into the Enrollment Agreement by this reference.

1. Sponsors' initial nonrefundable payment upon admission, as described in Sections 2 and 4B of the Enrollment Agreement, is \$2,750.00
  
2. Sponsors' personal financial obligation for the Ranch Program, which also reflects a discount on the actual tuition, will be \$7,982.50 month, months including therapy services. The Transitional Services fee is \$7,982.50 for one year service. A deposit of \$18,715.00 (1st month tuition and one year transitional service) is due upon admission. **The transitional services fee may not be applied to tuition or other expenses.** Sponsors shall make monthly payments thereafter, due on the first day of each month. Sponsors' personal financial obligation for the Ranch Program is hereafter referred to as "Sponsors Private Pay Responsibility." Sponsors will provide a credit card, which will be charged on the 1<sup>st</sup> day of each month.

Parent/Guardian Signature: \_\_\_\_\_

Credit Card Authorization

Student Name: \_\_\_\_\_

Visa                       MasterCard                       American Express

Account Number: ---

Expiration Date: /

Cardholder Name: \_\_\_\_\_

Cardholder Address: \_\_\_\_\_

Cardholder Phone Number: \_\_\_\_\_

Cardholder Fax Number: \_\_\_\_\_

Cardholder Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Dear Aspen Parent:

Attached, please find Form ICPC – 100A (the Interstate Compact Placement Request Form). This is an Interstate Compact, which in its essence informs the state of Utah that your child is coming into their state as a temporary resident. It, in turn, notifies your home state that your child will be temporarily residing in Utah. It is an agreement between the 50 states that, should your child ever be in need of government services, the receiving state (Utah) is agreeing to provide care and supervision while your home state agrees to bear the cost. While this form is generally a formality for Aspen placements, Aspen is required to have an approved Interstate Compact on file for each enrollee.

**(100A)** If you reside in any state **other than Utah**, it is imperative that **Section I** is completely filled out, **and**, the area labeled, **“Legal Status”**, in **Section II**, is completed. In addition, **your signature** must appear in the lower portion of **Section III** labeled, **“Signature of Sending Agency or Person”**, and dated. **(100B)** Section I must be filled out as well as a signature in Section IV where it is marked **“Person/Agency Supplying Information.”** **Please do not forget to sign and date.**

Any incomplete ICPC will be sent back to you to complete or sign.

Thank you for our promptness through this process, which allows us to help your children. If you are in need of further assistance, I can be reached between the hours of 8:00 a.m. and 5:00 p.m. Mountain Standard Time at (877) 231-0734 or (435) 836-1190

Sincerely,

*Liz Pace*

Liz Pace  
Admissions Counselor

**INSTRUCTIONS FOR COMPLETING FORM ICPC-100A  
INTERSTATE COMACT PLACEMENT REQUEST**

**Section I: IDENTIFYING INFORMATION**

Enter the full legal name, sex, ethnic group and birthdate of the child for whom this placement is proposed.

Use the following codes to enter the child's ethnicity: **W**=White: **H**=Hispanic: **B**=Black: **A**=Asian or Pacific Islander: **AI**=American Indian or Alaskan Native: **OT**=All other race/ethnic categories: **UK**=Unknown.

Enter the names of the legal mother and legal father. In cases where an adoption has been finalized, the adoptive parents will be the legal parents. If the parent(s) is deceased, enter "deceased" after the parent's name. if parental rights have been voluntarily relinquished or terminated by the court, indicate in parenthesis beside the name.

Enter the complete name, address and telephone number of the agency or person who is responsible for planning for the child and who is financially responsible for the child.

**Section II: PLACEMENT INFORMATION**

Legal Status Definitions:

**Sending Agency Custody/Guardianship:** child is in full legal custody or guardianship of the public social service agency or a licensed private child-placing agency.

**Parent Relative Custody/Guardianship:** child is not under the jurisdiction of either an agency or the court but is still the full legal responsibility of parent or relative.

**Court Jurisdiction Only:** the court has full responsibility for weighing the requested information and making the placement

**Parental Right Terminated:** sending agency has accepted voluntary relinquishment or parental rights.

**Please sign and date Section III where it is asking for the signature of the sending agency or person.**

**If you are in need of any further assistance, call  
(877)231.0734 or 435.836.1190 and speak to Liz Pace**

**INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN REQUEST**

TO:

FROM:

| SECTION I - IDENTIFYING DATA  |   |   |   |
|---|---|---|---|
| Notice is given of intent to place - Name of Child:   |   | Ethnicity: Hispanic Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unable to determine/unknown  |   |
| Social Security Number:   |   | CWA Eligible<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | Race:<br><input type="checkbox"/> American Indian or Alaskan Native<br><input type="checkbox"/> Asian<br><input type="checkbox"/> Native Hawaiian/ Other Pacific Islander<br><input type="checkbox"/> Black or African American<br><input type="checkbox"/> White |
| Sex:  | Date of Birth:  | Title IV-E determination<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending   |   |
| Name of Mother:   |   | Name of Father:   |   |
| Name of Agency or Person Responsible for Planning for Child:  |   |   | Phone:  |
| Address:  |   |   |   |
| Name of Agency or Person Financially Responsible for Child:   |   |   | Phone:  |
| Address:  |   |   |   |
| SECTION II - PLACEMENT INFORMATION  |   |   |   |
| Name of Person(s) or Facility Child is to be placed with:   |   | Soc Sec # (optional):<br>Soc Sec # (optional):  |   |
| Address:  |   | Phone:  |   |
| Type of Care Requested:   |   | <input type="checkbox"/> Parent<br><input type="checkbox"/> Relative (Not Parent)<br>Relationship: _____<br><input type="checkbox"/> Other: _____   | <input type="checkbox"/> ADOPTION<br><input type="checkbox"/> IV-E Subsidy<br><input type="checkbox"/> Non IV-E Subsidy<br>To Be Finalized In:<br><input type="checkbox"/> Sending State<br><input type="checkbox"/> Receiving State                              |
| <input type="checkbox"/> Foster Family Home   | <input type="checkbox"/> Residential Treatment Center         | <input type="checkbox"/> Institutional Care-Article VI, Adjudicated Delinquent  |   |
| <input type="checkbox"/> Group Home Care  |   |   |   |
| <input type="checkbox"/> Child Caring Institution   |   |   |   |
| Current Legal Status of Child:  |   | <input type="checkbox"/> Protective Supervision   |   |
| <input type="checkbox"/> Sending Agency Custody/Guardianship  | <input type="checkbox"/> Parent Relative Custody/Guardianship | <input type="checkbox"/> Parental Rights Terminated-Right to Place for Adoption   |   |
| <input type="checkbox"/> Court Jurisdiction Only  |   | <input type="checkbox"/> Unaccompanied Refugee Minor  |   |
|   |   | <input type="checkbox"/> Other: _____   |   |
| SECTION III - SERVICES REQUESTED  |   |   |   |
| Initial Report Requested (if applicable):<br><input type="checkbox"/> Parent Home Study<br><input type="checkbox"/> Relative Home Study<br><input type="checkbox"/> Adoptive Home Study<br><input type="checkbox"/> Foster Home Study   |   | Supervisory Services Requested:<br><input type="checkbox"/> Request Receiving State to Arrange Supervision<br><input type="checkbox"/> Another Agency Agreed to Supervise<br><input type="checkbox"/> Sending Agency to Supervise | Supervisory Reports Requested:<br><input type="checkbox"/> Quarterly<br><input type="checkbox"/> Semi-Annually<br><input type="checkbox"/> Upon Request<br><input type="checkbox"/> Other: _____  |
| Name and Address of Supervising Agency in Receiving State:  |   |   |   |
| Enclosed: <input type="checkbox"/> Child's Social History <input type="checkbox"/> Court Order <input type="checkbox"/> Financial/Medical Plan <input type="checkbox"/> Other Enclosures<br><input type="checkbox"/> Home Study of Placement Resource <input type="checkbox"/> ICWA Enclosure <input type="checkbox"/> IV-E Eligibility Documentation |   |   |   |
| Signature of Sending Agency or Person:  |   |   | Date:   |
| Signature of Sending State Compact Administrator, Deputy or Alternate:  |   |   | Date:   |
| SECTION IV - ACTION BY RECEIVING STATE PURSUANT TO ARTICLE III(d) of ICPC   |   |   |   |
| <input type="checkbox"/> Placement may be made  |   | <input type="checkbox"/> Placement shall not be made  |   |
| REMARKS:  |   |   |   |
| Signature of Receiving State Compact Administrator, Deputy or Alternate:  |   |   | Date:   |

DISTRIBUTION (Complete six (6) copies):  
 \* Sending Agency retains a (1) copy and forwards completed original plus four (4) copies to:  
 \* Sending Compact Administrator, DCA, or alternate retains a (1) copy and forwards completed original and three (3) copies to:  
 \* Receiving Agency Compact Administrator, DCA, or alternate who indicates action (Section IV) and forwards a (1) copy to receiving agency and the completed original and one (1) copy to sending Compact Administrator, DCA, or alternate within 30 days.  
 \* Sending Compact Administrator, DCA, or alternate retains a completed copy and forwards the completed original to the sending agency.

INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN  
REPORT ON CHILD'S PLACEMENT STATUS

TO:

FROM:

| SECTION I - IDENTIFYING INFORMATION  |   |   |   |
|--|---|---|---|
| Child's Name: _____  | Birthdate: _____                              |   |   |
| Mother's Name: _____   | Father's Name: _____                          |   |   |
| SECTION II - PLACEMENT STATUS  |   |   |   |
| <input type="checkbox"/> Initial Placement of Child in Receiving State                                       | Date Child Placed in Receiving State: _____   |   |   |
| Name of Resource: _____  |   |   |   |
| Address: _____   |   |   |   |
| Type of Care: _____  |   |   |   |
| <input type="checkbox"/> Placement Change  | Effective Date of Change: _____               |   |   |
| Name of Resource: _____  |   |   |   |
| Address: _____   |   |   |   |
| Type of Care: _____  |   |   |   |
| SECTION III - COMPACT PLACEMENT TERMINATION  |   |   |   |
| <input type="checkbox"/> Adoption Finalized  | <input type="checkbox"/> In Sending State     | <input type="checkbox"/> In Receiving State | <input type="checkbox"/> Court Order Attached |
| <input type="checkbox"/> Child Reached Majority/Legally Emancipated  |   |   |   |
| <input type="checkbox"/> Legal Custody Returned to Parent(s)   | <input type="checkbox"/> Court Order Attached |   |   |
| <input type="checkbox"/> Legal Custody Given to Relative   | <input type="checkbox"/> Court Order Attached |   |   |
| Name: _____  |   | Relationship: _____                         |   |
| <input type="checkbox"/> Treatment Completed   |   |   |   |
| <input type="checkbox"/> Sending State's Jurisdiction Terminated with the Concurrence of the Receiving State |   |   |   |
| <input type="checkbox"/> Unilateral Termination  |   |   |   |
| <input type="checkbox"/> Child Returned to Sending State   |   |   |   |
| <input type="checkbox"/> Child Has Moved to Another State  |   |   |   |
| <input type="checkbox"/> Proposed Placement Request Withdrawn  |   |   |   |
| Name of Placement Resource: _____  |   |   |   |
| <input type="checkbox"/> Approved Resource Will Not Be Used for Placement                                    |   |   |   |
| Name of Approved Placement: _____  |   |   |   |
| <input type="checkbox"/> Other (Specify): _____  |   |   |   |
| <b>Date of Termination:</b> _____  |   |   |   |
| SECTION IV - SIGNATURES  |   |   |   |
| Person/Agency Supplying Information: _____   | Date: _____                                   |   |   |
| Compact Administrator, Deputy or Alternate: _____  | Date: _____                                   |   |   |

DISTRIBUTION (Complete four (4) copies of this form):

- Sending Agency retains a (1) copy and forwards completed original plus three (3) copies to:
- Sending Compact Administrator, DCA, or alternate retains one (1) copy and forwards two (2) copies to:
- Receiving Agency Compact Administrator, DCA, or alternate retains one (1) copy and forwards one (1) copy to the receiving agency

# Aspen Ranch Program Details

We realize you are making an important decision during a time that might be filled with significant emotional crisis for you. As you make your decision, we want to be sure you understand some important components of the Aspen Ranch program. Please initial after each detail component to indicate your understanding and acceptance.

- In order to facilitate a therapeutic and trusting transition, students need to be told before arriving at Aspen Ranch that they will be staying at the program. The student may be told sometime during transit with parents or escorts. \_\_\_\_\_ (initial)
- In order to maintain a safe environment for students and staff, we will conduct a thorough intake which includes a strip search and search of all belongings upon admission and upon return of all off campus visits with parents. \_\_\_\_\_ (initial)
- You will be contacted upon completion of your child's initial intake. The parent coordinator will call you within the first three days of treatment to answer questions and give you an update on how your child is adjusting. Your child's therapist will contact you within the first four or five days of treatment after they've had an opportunity to work with your son or daughter on a couple of occasions. Your child's academic advisor will contact you within the first month of treatment to discuss academic goals and progress. \_\_\_\_\_ (initial)
- Your child will be provided most of the items he or she will need at Aspen Ranch. It is not necessary to send toothpaste, shampoo, lotion, etc with him or her. If your child wears a retainer, glasses or contacts—please send these things. Items you will need to provide your child include an electric razor (no battery operated ones), cowboy boots, hiking boots and athletic shoes, sleeping bag, twin sized comforter, 30 day supply of medication, contact solution if applicable. \_\_\_\_\_ (initial)
- During treatment, the relationship that we are most striving to restore is the parent/child relationship with both parents. Because of this, parents can write letters, faxes and emails to the child immediately upon admission. Other family members can write letters later in the child's treatment as he or she moves through the levels system. Students can only receive letters from friends in the final stages of treatment and only with parental approval. \_\_\_\_\_ (initial)
- Typically, the first eight weeks in the program are a time of orientation and emotional adjustment for the student and family. Our experience has indicated that it is more productive when family and student have made this adjustment separately. Therefore, parent visits can be set up with the therapist after the eighth week in treatment. \_\_\_\_\_ (initial)
- Parents will receive a contact from the primary therapist at the prearranged times. The student will be present for at least one family session via teleconference each month after the blackout period. The student will be increasingly present for phone calls as treatment needs dictate and as the student gets closer to going home. \_\_\_\_\_ (initial)
- If parents are separated or divorced, calls will be conducted with both parents on conference call. If the relationship is such that parents cannot be conferenced in on the same call, the time that the therapist or parent coordinator can spend on the call will be split between the two parties. \_\_\_\_\_ (initial)
- The minimum time that a student can complete the program is nine months. For most students, completion of the program will take longer than nine months. \_\_\_\_\_ (initial)
- An important component of each student's treatment is the work his or her parents do to improve themselves and their relationships. Parents need to be committed to their own therapeutic work while their child is in treatment. This should include work with a clinician at home in conjunction with the work in family therapy sessions over the phone. A minimum of (2) parent education workshops and Family Enrichment is required. \_\_\_\_\_ (initial)
- During the first month your child is in treatment, we understand your anxiety may be higher as you come to understand the program and the work that he or she will be doing here. During this time, you can expect a call or email at least once a week from the parent coordinator providing you with updates and answering any questions that you might have. Please know that though we are a 24 hour facility, we do not have 24-hours-a-day, 7-days-a-week office hours. During traditional business hours (M-F 8-5 p.m.), our phones are staffed by office personnel. During non-traditional business hours, our phones are answered by staff that have a myriad of other responsibilities. We ask that you contain non-traditional business hour calls to emergencies. \_\_\_\_\_ (initial)
- We retain the services of a psychiatrist who visits the Ranch once a month. She does an initial evaluation on each student. She sees students on an on-going basis as needed. We also retain the services of an Family Nurse Practitioner who visits the Ranch once a week. We can accommodate other medical needs—dentist, orthodontist, optometrist, etc by off campus visits to local practitioners.

There is an escort fee associated with this service. Students need to come to the Ranch with two to three weeks worth of current medications. Future prescriptions will be filled by Lin's Pharmacy, Richfield Utah. \_\_\_\_\_ (initial)

- Parents are responsible for payment of any medical services not covered by medical insurance. \_\_\_\_\_ (initial)
- We do not administer herbal medications. The following dietary supplements can be administered: Multivitamin, Vitamin C, Vitamin E, Calcium, Folic Acid (girls), Omega 3 (upon physician approval). If you choose any of the above additional supplements for your child, they will be obtained from Lins Pharmacy. \_\_\_\_\_ (initial)
- There is a small pond on campus that is used in the summer for canoeing and swimming. It freezes in the winter, but does not freeze safely and consistently enough for winter sports on the ice. \_\_\_\_\_ (initial)
- Students who attain Rider or Wrangler are eligible for off campus trips that may include hikes, visits to National Parks, snowboarding, river rafting and trail rides. These are privileges that students must earn. Typically, students are not able to earn this level and these privileges until they've been in treatment for at least 6 months. \_\_\_\_\_ (initial)
- Aspen Ranch is a Residential Treatment Center. Students should not be placed at Aspen Ranch if the parents perceive that he or she only needs to work on school. For a child to be successful in all aspects of the program, the parent's attitude needs to embrace all aspects of the program. \_\_\_\_\_ (initial)
- An important component of our program is the work that the students do with horses. Students have an Equine class that focuses on Horsemanship a minimum of once per week. Likewise, they have an Equine Assisted Psychotherapy session once a week. . \_\_\_\_\_ (initial)
- Aspen Ranch is accredited through the Northwest Association of Accredited Schools. As such, all high school credits are recognized nationally. Aspen Ranch offers a college preparatory track, but does not offer Advanced Placement options. Students have the opportunity to take basic courses required for high school graduation and college placement. We do not provide college placement services—though students may do this research on their own as they progress through treatment. Aspen Ranch offers a foreign language (Spanish I & II) in its general courses offerings. Students may take a foreign language through a correspondence course available through Brigham Young University. Parents are responsible for the extra fee that this incurs. \_\_\_\_\_ (initial)
- Aspen Ranch provides individualized instruction and the opportunity for students to move at an accelerated rate through classes. Program incentives offer some external motivation for students to work through classes, but students must also find some internal motivation. Our experience indicates that success breeds success. Many students find success in this small, individualized school for the first time ever. They become motivated by this success. Parents should understand that academic progress waxes and wanes relative to therapeutic progress. \_\_\_\_\_ (initial)
- Students must complete the program in order to receive transitional services. If you elect to terminate your child's care prior to his/her completion of the program, you forfeit the \$7,982.50 pre-paid fee for transitional services. \_\_\_\_\_ (initial)
- Upon admission, your child will be assigned a team. During the course of treatment, it may become beneficial to move your child to a different team for therapeutic reasons. \_\_\_\_\_ (initial)
- Monthly tuition covers room & board, supervision, therapeutic care and academics. In addition, parents will pay for miscellaneous expenses including: escort fees, clothing & hygiene products, minor school supplies, birthday cakes, activities and SAT/ACT testing. \_\_\_\_\_ (initial)

I understand and accept the above listed and initialed Aspen Ranch Program Details.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

Date

**NOTICE OF PRIVACY PRACTICES**  
**OF**  
**ASPEN EDUCATION GROUP AND ITS AFFILIATED ENTITIES**

**Effective Date: April 14, 2003**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact \_\_\_\_\_

**WHO MUST FOLLOW THE REQUIREMENTS OF THIS NOTICE?**

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Aspen Education Group and its affiliated entities (collectively, "Aspen") must take steps to protect the privacy of your "protected health information" (referred to in this Notice as "PHI" or "health information"). PHI includes information that we have created or received regarding your health or payment for your health. It includes both your medical records and personal information such as your name, social security number, address, and phone number.

Aspen Education Group is an organization that is committed to improving the quality of life for youth and their families. Aspen operates 48 programs in nine states that provide innovative quality educational programs that promote academic and personal growth. The services provided by Aspen's programs are diverse and, in some cases, the provision of health care treatment and services may be the primary function – for example, the provision of mental health services by Aspen Community Services – or, in other cases, the provision of health care treatment may be a secondary or ancillary function -- for example, a nurse's office located on an Aspen school campus. Aspen also operates an employee benefit health plan for the benefit of its employees.

All of these programs, functions and services operated or provided by Aspen are conducted through separate but affiliated entities which are identified on Exhibit A attached to this Notice. Under the privacy standards contained in HIPAA, legally separate but affiliated entities may designate themselves as a single covered entity for compliance purposes. Accordingly, this Notice constitutes notice of the privacy practices for all of the Aspen-affiliated entities, sites and locations that are listed on the attached Exhibit A, which will follow the terms of this Notice. In addition, these entities, sites and locations may share health information with each other for treatment, payment or health care operations purposes as described in this Notice. All Aspen employees are required to maintain the confidentiality of PHI in accordance with this Notice and receive appropriate privacy training.

Please note, however, that this Notice of Privacy Practices does not apply to student medical records that are maintained by Aspen's four special education day schools in Southern California -- Hawthorne Academy, Rossier Park High School and Elementary School, and Leeway School. The reason is that these schools are subject to the Federal Educational Rights and Privacy Act ("FERPA") resulting from their receipt of indirect funding from the U.S. Department of Education. The privacy rights and protections afforded to student medical records maintained by those schools will be governed by FERPA instead.

**RESPONSIBILITIES OF ASPEN EDUCATION GROUP AND ITS AFFILIATED ENTITIES**

We are required by law to:

- Make sure that health information that identifies you is kept private (with certain exceptions);
- Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of this Notice that are currently in effect.

This Notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

**USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION BY ASPEN THAT DO NOT REQUIRE YOUR AUTHORIZATION**

Aspen uses and discloses protected health information in a number of ways connected to the provision of health care treatment and services, payment for care, and our health care operations. Some examples of how we may use or disclose your health information without your authorization are listed below.

**We may use or disclose your protected health information without your authorization as follows connected to the provision of health care treatment and services:**

- To physicians, nurses, and others involved in your health care or preventive health care.
- To other health care providers treating you such as hospitals, pharmacies, labs, emergency room staff and specialists. For example, if you are being treated for an injured knee, we may share your health information among your primary physician, the knee specialist, and your physical therapist so they can provide proper care.

**We may use or disclose your protected health information without your authorization as follows in relation to payment for care:**

- To administer your health benefits policy or contract (for Aspen Education Group Employee Benefit Plan members).
- To bill you for health care we provide.
- To pay others who provided care to you.
- To other organizations and providers for payment activities unless disclosure is prohibited by law.

**We may use or disclose your protected health information without your authorization as follows in relation to health care operations:**

- To administer and support our business activities or those of other health care organizations (as allowed by law) including providers and plans. For example, we may use your health information to review and improve the quality of care you receive, to provide training, and to evaluate the performance of our staff in caring for you.
- To other individuals (such as consultants and attorneys) and organizations that help us with our business activities. (Note: If we share your health information with other organizations for this purpose, they must agree to protect your privacy.)

**We may use or disclose your protected health information without your authorization for legal and/or governmental purposes in the following circumstances:**

- As required by law -- When we are required to do so by federal, state or local law.
- Public health and safety -- To an authorized public health authority or individual for public health and safety purposes, including to:
  - Protect or prevent a serious threat to the health and safety of the public or of another person.
  - Prevent or control disease, injury, or disability.
  - Report vital statistics such as births or deaths.

- Report reactions to medications or problems with products and notify people of recalls of products they may be using. (Food and Drug Administration.)
- Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- Notify an employer concerning work-related injuries or illnesses or workplace medical surveillance in situations where the employer has a duty under federal or state law to keep records on or act on such information.
- Abuse or neglect -- To the appropriate government authority authorized to receive reports regarding abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law. However, no consent is required in cases involving child abuse or neglect.
- Health oversight activities -- To health oversight agencies for certain activities such as audits, investigations, inspections and licensure.
- Lawsuits and disputes -- In the course of any legal proceeding, in response to an order of a court or administrative agency. Also, in certain cases, in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.
- Law enforcement -- To law enforcement officials in limited circumstances for law enforcement purposes. For example disclosures may be made to identify or locate a suspect, witness, or missing person; to report a crime; or to provide information concerning victims of crimes.
- Military activity and national security -- To the military (if you are a member of the armed forces), and to authorized federal officials for national security and intelligence purposes or in connection with providing protective services to the president of the United States.
- Workers' compensation -- Where authorized by law in order to comply with the workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**We may also use or disclose your protected health information without your authorization in the following miscellaneous circumstances:**

- Facility directory information -- Unless you object, we may use and disclose your name, the location at which you are receiving care, your general condition (e.g., fair, stable, etc.), and your religious affiliation in our facility directory. All of this information except religious affiliation will be disclosed to people who ask for you by name. Members of the clergy (such as a priest or rabbi) will be told your religious affiliation if they ask (but they don't have to ask for you by name). This is to help your family, friends, and clergy visit you in the facility and generally know how you are doing.
- Family and friends -- Unless you object, we may disclose health information about you to a family member, relative, a close friend - or any other person you identify who is directly involved in your health care - who is involved in your care or who helps pay for your care. If you are either not present or unable to make a health care decision for yourself and we determine that disclosure is in your best interest, we may also disclose such health information about you to those persons. For example, we may disclose health information to a friend who brings you into an emergency room.
- Appointment reminders -- To remind you that you have a health care appointment with us. These reminders may be made by postcard, phone, or voicemail unless you specifically ask us to communicate with you through a different method as described later in this Notice.
- Treatment alternatives and health-related services -- To communicate with you about treatment services, options, or alternatives, as well as health-related benefits or services that may be of interest to you.
- Employer group health plans -- For Aspen Education Group Employee Benefit Plan members, we may communicate with your employer for certain administrative activities.
- Health insurance underwriting -- For Aspen Education Group Employee Benefit Plan members, we may use your health information for underwriting, premium rating or other health insurance-related activities
- Research -- For research purposes provided that certain steps are taken to protect your privacy. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose health information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the facility
- De-identify information -- To "de-identify" information by removing information from your health information that could be used to identify you.
- Disaster relief -- To an authorized public or private entity for disaster relief purposes. For example, we might disclose your health information to help notify family members of your location or general condition.
- Coroners, funeral directors, and organ donation -- To coroners, funeral directors, and organ donation organizations as authorized by law.
- Correctional institution -- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official for certain purposes, such as (1) providing health care to you by the institution; (2) protecting your health and safety or the health and safety of others; or (3) protecting the safety and security of the correctional institution.

**USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION BY ASPEN THAT REQUIRE US TO OBTAIN YOUR AUTHORIZATION**

Except in the situations listed in the sections above, we will use and disclose your health information only with your written authorization. If you sign an authorization you may revoke it at any time in writing, although this will not affect information that we disclosed before you revoked the authorization. If you would like to ask us to disclose your health information, please contact the Aspen Privacy Officer at (562) 467-5500 for an authorization form. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

**YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION**

You have the right to:

- Restrictions on use or disclosure -- Request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Please note that we are not required to agree to your request. If we do agree, we will honor your limits unless it is an emergency situation. To request restrictions, you must make your request in writing to the Aspen Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.
- Confidential Communications -- Request that we communicate with you about health matters by another means or at another location. For example, if you want us to communicate with you at a different address we can usually accommodate that request. Any request must be made in writing to the Aspen Privacy Officer. Your request must specify how or where you wish to be contacted. We will agree to reasonable requests.
- Inspect and copy -- Inspect and copy health information that may be used to make decisions about your care. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to the Aspen Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. In certain situations we may deny your request and will tell you why we are denying it. In some cases you may have the right to ask for a review of our denial.
- Amend -- If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Aspen. To request an amendment, your request must be made in writing and submitted to the Aspen Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for Aspen;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

- Accounting of disclosures – Request an "accounting of disclosures." This is a list of the disclosures we made of health information about you other than our own uses for treatment, payment and health care operations, (as those functions are described above) and for other exceptions pursuant to the law. To request this list or accounting of disclosures, you must submit your request in writing to the Aspen Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- Paper copy -- Request a paper copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

#### **CHANGES TO PRIVACY PRACTICES**

Aspen may change the terms of this Notice at any time. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. If we change any of the practices described in this Notice, we will post the revised Notice on enrollee-accessible web sites and at Aspen clinic sites. The notice will contain on the first page, in the top right-hand corner, the effective date.

#### **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with Aspen or with the Secretary of the Department of Health and Human Services. To file a complaint with Aspen, write to Ruth Moore, Vice President, Corporate Compliance, at 17777 Center Court Drive, Suite 300, Cerritos, CA 90703. For more information on how to file a written complaint, contact the Aspen Privacy Officer at (562) 467-5500. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

#### **QUESTIONS**

If you have any questions about this Notice or would like an additional copy, please contact the contact the Aspen Privacy Officer at (562) 467-5500.

**ACKNOWLEDGEMENT OF RECEIPT**

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Aspen Education Group and its affiliated entities. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our Notice, you may request a copy of the revised notice by accessing our web site (<http://www.aspeneducation.com>) or contacting our organization at (562) 467-5500. If you have any questions about our Notice of Privacy Practices, please contact Aspen's Privacy Officer at (562) 467-5500.

I acknowledge receipt of the Notice of Privacy Practices of Aspen Education Group and its Affiliated Entities.

Signature: \_\_\_\_\_  
(individual/parent/conservator/guardian)

Date: \_\_\_\_\_

**INABILITY TO OBTAIN ACKNOWLEDGEMENT**

[To be completed only if no signature is obtained.]

If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of Aspen representative: \_\_\_\_\_

Date: \_\_\_\_\_