Authorization for Photographing and Consent/Use of Images

Third Way Center respects the privacy of our residents, visitors and staff. Third Way Center seeks your consent to allow us to take and use photographic material of you. To ensure that Third Way Center is acting in accordance with your wishes, and using your personal information with your authorization, we ask you to fill out and sign this form. Third Way Center will keep a copy of your written permission on file.

Client Name:	**Birth Date:**

Purpose of Use/Disclosure:

☐ For use in Third Way Center's client file (hardcopy or electronic)

☐ For use in the Third Way Center school yearbook

☐ For use in the Third Way school graduation presentation or slide show.

☐Other: _____ _____ _____ _____ _____

Description of Protected Health Information to be Used or Disclosed:

☐ All Client Identifying Information; or ☐ Age/Date of Birth ☐ City of Residence ☐ Name	☐ Photograph/Digital Image	

☐ I _____ (personal representative of the Client) further give permission for my image and name to be used in the school yearbook

☐ I _____ (personal representative of the Client) further give permission for my image and name to be used in the school graduation presentation or slide show.

I am not required to sign this authorization. Third Way Center does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form. I have been provided with a copy of this authorization. I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of any identifying information and/or photographic material.

If I decide to sign this form, I have the right to request that photographing cease at any time, so long as my request is made in writing. I understand that my revocation will not affect any actions taken prior to Third Way Center's receipt of my written revocation.

I am aware that my protected health information will exist forever in either a recorded, printed, and /or electronic version or other version as may develop over time and that once it is published or disclosed in any form it will continue to be used. I understand that information about the Client used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state law.

This consent will remain in effect until revoked in writing or until the client is discharged from Third Way Center, whichever occurs first.

_____ _____ _____ ____ _____

Signature Date

For personal representatives, please provide the following:

I _____ represent that I am the health care agent/guardian/surrogate/parent of the client above.
(insert your name) (circle one of the above)

_____

Personal Representative Signature (Required for clients 17 years of age and under for adult clients with a court-appointed legal guardian)

RELEASE OF RESPONSIBILITY – PROPERTY POLICY

I understand that Third Way Center is not responsible for my personal belongings and that I should not bring to Third Way Center any item that I am unwilling to lose. Due to the nature and number of residents, Third Way Center is not a secure environment. In the rooms or apartments, clients should always ensure that his/her door is closed and locked securely when leaving.

It is Third Way Center's policy to keep clients' belongings for a maximum of 30 days following their termination from the program. It is the responsibility of the caseworker or parents to pick up the client's property. After 30 days, all belongings will be donated to charity.

Third Way Center will not be responsible for belongings left behind by a client who is AWOL from the program.

Televisions, stereos, cell phones, computers, gaming devices, and radios must be operated according to Third Way Center policies.

Issues of stealing, lending, or missing items will be addressed in house/community meetings. All financial remunerations evolving from such conflicts will be the responsibility of the involved residents and not Third Way Center.

Third Way Center will do everything reasonable and within its authority to resolve issues of stealing, lending, and missing items.

Client Signature: _____ Date: _____

Client Manager or Caseworker Signature: _____

Parent/Guardian Signature: _____

AUTHORIZATION FOR GENERAL MEDICAL AND DENTAL CARE

CONSENT FOR OVER-THE-COUNTER MEDICATION: Over-the-counter (OTC) medications are drugs that do not require a prescription and are purchased "Over-the-counter." Third Way Center stocks several OTC meds which will be dispensed in accordance with the directions on the label unless directed otherwise by the physician

CROSS OUT medications that the resident SHOULD NOT be given.

Tylenol (Acetaminophen) Bactine (antiseptic) Calamine Chloraseptic Throat Spray
Clotrimazole (antifungal) Dayquil (acetaminophen/DM/phenylephrine)
Diphenhydramine (Benadryl) Fish Oil Guaifenesin DM (cough syrup)
Hydrocortisone 1% cream Motrin (Ibuprofen) Immodium (antidiarrheal)
Claritin (Loratadine) Maalox Miralax (laxative)
Nyquil (acetaminophen/DM/doxylamine) Pseudoephedrine (Sudafed)
Triple Antibiotic Ointment Tums Other _____

I hereby give permission to Third Way Center to provide, seek, and consent to routine health care, including, but not limited to, first aid and symptomatic treatments for minor conditions, including over the counter medications, as limited herein, administration of prescribed medications, and emergency care for _____, ("the client"), as may be necessary, including, but not limited to, x-rays, routine tests and treatment, and/or hospitalization. I also give permission for Third Way Center to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

It is my intention that Third Way Center be treated as acting *in loco parentis* if the client herein named is a minor. Further, it is my intention that the appropriate representatives of Third Way Center be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations of the Health Information Portability and Accountability Act (HIPAA). I hereby agree that I have disclosed to Third Way Center, as necessary: (I) all relevant information to the client's ability to participate in activities, (II) all relevant information regarding the client's health history and (III) all information necessary to keep me informed of the client's health status.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by Third Way Center to secure and administer treatment, including hospitalization, for the client.

_____ _____
Signature of Caseworker or Client Manager Date Signed

_____ _____
Signature of Parent or Guardian Date Signed

RE: _____ _____ DATE: _____

SCHOOL RECORDS RELEASE

I hereby authorize ____ ***all previous schools*** to furnish copies of the following information:

☒ Audiometric

☒ Educational

☒ Immunization Record

☒ Occupational Therapy

☒ Special Education Records
(especially Individual Ed. Program
providing date and designation of handicap)

☒ Disciplinary Actions

☒ Physical Therapy

☒ Psychiatric

☒ Psychology

☒ Social Work

☒ Speech/Language

☒ Attendance

☐ Other (specify)_____ _____

This release of information pertains to:

Student Legal Name: _____
Last First Initial

Date of Birth: _____ Student Number: _____

This release of information remains in effect until **DISCHARGE FROM** TREATMENT WITHIN THIRD WAY CENTER.

The undersigned acknowledges that he/she/they understand that this release remains in effect until the above date or event, unless specifically revoked by written notice.

_____ _____
Signature of Client Date

_____ _____
Person Authorized to Give Consent Date

☒ Please FAX to: _____ 720-570-3847

*To revoke consent, please refer to the Third Way Center Revocation of Consent for Release

THIRD WAY CENTER

School Enrollment Information

Name: _____ **DOB**: _____

School:_____ **Date Enrolled**: _____ **Date Started**: _____

Date Withdrawn: _____ **Special Ed**: yes ☐ no ☐ **IEP on file**: yes ☐ no ☐

Parents Names: _____

Parents Address: _____

Are Parental Rights Terminated? yes ☐ no ☐

District of Jurisdiction: (If unavailable, list county) _____

Status Changes:

Date Re-entered: _____ Date Withdrawn or AWOL: _____

Date Re-entered: _____ Date Withdrawn or AWOL: _____

Date Re-entered: _____ Date Withdrawn or AWOL: _____

Date Re-entered: _____ Date Withdrawn or AWOL: _____

Date Re-entered: _____ Date Withdrawn or AWOL: _____

Approved Facility Schools

Home Language Survey

Federal and State regulations require schools to determine the language(s) spoken and understood by each student. This information is necessary for schools to provide appropriate instruction. If another language is reported to be spoken or heard in the home it indicates that the student may need to be tested in speaking, listening, reading and writing in English.

Please fill out one (1) form for every student enrolled.

Student's name _____
(Last name or Family name) (First given name) (Second given name)

Country of Birth _____ Date of Birth _____

Facility School Joan Farley Academy School Year _____ Grade Level _____

1. What language(s) did the student use when he/she began to talk? _____
2. What language(s) does the student speak with family at home? _____
3. What language(s) do parents use when they speak to student? _____
4. What language(s) do other adults in the home speak to student? _____
5. What language(s) does student read? _____ write? _____
6. Did the student attend school in another country? No _____ Yes _____
7. If "yes", which country? _____ How many years? _____
8. Language(s) used for instruction in the other country? _____ __
9. How many years has the student been in the USA?_____in Colorado?_____

Name of Person providing information_____ Date _____

This person is _____ parent

_____ other family member (Specify:_____ __)

_____ foster parent

_____ case worker / client manager

_____ other (Specify: _____)

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW THIRD WAY CENTER USES MEDICAL INFORMATION ABOUT ITS CLIENTS, HOW MEDICAL INFORMATION CAN BE RELEASED TO OTHERS AND HOW MEDICAL INFORMATION MAY BE ACCESSED. PLEASE REVIEW IT CAREFULLY.

This Notice describes how Third Way Center protects the personal health information that we have about our clients which relates to health care services received from us and how we may use and disclose this information. It also describes a client's right to access and control their personal health information. "Personal health information" is information about a client that may identify the client and that relates to the client's medical condition, the health care services received, any plan for future care, or the payment for health care services provided the client.

We understand a client's health information is personal, and we are committed to protecting this information. This Notice applies to all of the records relating to a client's health that we maintain, whether created by us or another provider.

How We May Use and Disclose a Client's Personal Health Information

Treatment, Payment and Health Care Operations: A Third Way Center client's personal health information may be used and disclosed by their physician, our staff, and others outside of Third Way Center that are involved in the clients care and treatment for the purpose of providing health care services, to pay health care bills, to support the operations of Third Way Center and any other use required by law.

- Treatment - We may use and disclose health information about a client to provide, coordinate or manage their health care and related services. This includes coordination of health care with a third party. For example, we may send personal health information to a specialist as part of a referral. In addition, to the extent that a client receives education services on campus as part of their treatment plan, we will share health information about the client with educators within our program that is needed by the educators to provide appropriate services to the client.
- Payment – A client's personal health information will be used, as needed, to obtain payment for their health care services. For example, we may give a client's health plan, or the third party administrator who manages their health plan, information about services the client received at Third Way Center so that their health plan will pay us or reimburse the client for the services of Third Way Center.
- Health Care Operations - We may use and disclose personal health information to support the operations of Third Way Center. These uses and disclosures are necessary to run Third Way Center and make sure that all of our patients receive quality care. For example, we may use personal health information to review our treatment and services.

Other Uses and Disclosures

We may use or disclose a client's personal health information for the following purposes without their authorization, as needed. These situations include**:** as Required by law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation.

The following examples describe different ways that we may use and disclose a client's personal health information:

- To contact a client for appointment reminders and to provide information about or recommend possible treatment options or alternatives that may be of interest to the client.
- To a friend or family member who is involved in a client's care (such as to help with follow-up care).
- To our business associates if they need to receive personal health information to provide a service to us. Examples of such business associates are billing companies or data processing companies. Our business associates are also required to keep Third Way Center's client's personal health information confidential.
- To government regulatory agencies that have a right to collect health information or for audits, inspections and investigations.
- To law enforcement officials in response to a request made through a court order, subpoena, warrant, summons or to prevent danger or injury.
- To prevent a services threat to life or safety of a person or the public.

Other permitted and required uses and disclosures will be made only with a client's or their parent/legal representative's consent, authorization, or opportunity to object unless required by law. The authorization may be revoked in writing, at any time. Such authorization will be effective except to the extent that we have taken action in reliance on the authorization or if the client's authorization was obtained as a condition of obtaining health care services.

Rights Relating to Personal Health Information

- Right to Inspect and Copy Personal Health Information – In most cases, a client at Third Way Center has the right to inspect and obtain a copy of their personal health information that we maintain for as long as we maintain it. If a client wants to copy their personal health information, they may be charged a fee for the costs of copying and mailing the information. In limited circumstances, we may deny a client's request to review or obtain a copy of your personal information. If we deny the request, we will advise the client in writing of the reasons for the denial and explain their right to have the denial reviewed.
- Right to Amend Personal Health Information – If a client believes information that we maintain is incorrect or if important information is missing, they have the right to request that we amend it. We may deny the request to amend the information under certain circumstances. If we deny a client's request, they have the right to file a statement of disagreement with us and we may prepare a rebuttal to their statement and will provide the client with a copy of any such rebuttal.
- Right to Obtain a List of the Disclosures Third Way Center Has Made – The first list a client requests within a 12-month period will be free. We may charge for our costs in responding to any additional requests.
- Right to Request Restrictions on the Use and Disclosure of Personal Information – Third Way Center clients have the right to ask us not to use or disclose any part of their personal health information for the purposes of treatment, payment or healthcare operations. Their request must state the specific restriction and to whom they want the restriction to apply. We are not required to agree to a requested restriction. If the client's physician believes that is in the client's best interest to permit use and disclosure of their personal health information, the client's personal health information will not be restricted. The client then has the right to use another healthcare professional.
- Right to Request Confidential Communications – A client has the right to request that we communicate about personal health information in a certain way or at a certain location. For example, they may request that we only make contact them at work or by mail. We will accommodate all reasonable requests.
- Right to Obtain a Copy of this Notice – Clients, parents and/or legal guardians have the right to request a copy of this Notice. A copy will be provided to by request.

Complaints and Reporting Violations

A client, parent and/or legal guardian may file a complaint if they believe privacy rights have been violated under HIPAA. Under no circumstances will they be penalized or retaliated against for filing a complaint.

Complaints may be sent to:

- David Eisner, Third Way Center (303) 780-9191
  PO Box 61385
  Denver, CO 80206
- Office for Civil Rights (303) 844-2024
  U.S. Department of Health & Human Services
  1961 Stout Street - Room 1426
  Denver, CO 80294

Violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

We reserve the right to change the terms of this Notice and will inform clients, parents, or legal guardians of any changes by posting a revised notice on the bulletin board at each facility and will make a revised notice available in the staff office. Clients, parent and legal guardians then have the right to object or withdraw as provided in this notice.

If a client wishes to request any of the above rights or if a client has any questions about our privacy practices, they may contact the Privacy Officer at PO Box 61385, Denver, CO 80206 or (303) 780-9191 ext. 62. Our Privacy Officer may be contacted if a client, parent or legal guardian has questions or comments about our privacy practices.

This notice becomes effective on April 14, 2003.

PLEASE GIVE THE CLIENT THE NOTICE OF PRIVACY PRACTICES AND FILE THIS ACKNOWLEDGEMENT IN THE CLIENT FILE.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge receiving a complete copy of the Notice of Privacy Practices of Third Way Center on this ___ day of _____, 20___.

_____
Signature of Client

_____
Signature of Parent or Legal Guardian

CONSENT FOR FOLLOW UP CONTACT

I hereby grant permission of the staff of Third Way Center to contact me, my parents and my caseworker or client manager after my discharge, for the program to obtain information for the purpose of identifying the impact of services I received. All information will be considered confidential. I understand that no names will be used in reports.

Client:_____ _____ Date:_____

Parent/Guardian:_____ _____ Date:_____

Witness:_____ _____ Date:_____

I also grant permission for Third Way Center to contact the following individual(s) after my discharge:

_____ _____

Name Name

_____ _____

Name Name

These individuals will serve as informants, providing additional information about my progress. This information will also be considered confidential.

CONSENT TO TREATMENT, TESTING AND ASSESSMENT
AND
ACKNOWLEDGEMENT OF CONFIDENTIALITY

Client Name:_____

I consent, assent if a minor, to receive ongoing assessment, testing, and treatment for the purpose of addressing issues related to familial, behavioral, emotional, social, educational, psychological, physical, and substance abuse problems from Third Way Center. I understand that a treatment team under the supervision of a licensed clinician will be providing all relevant services to me. I understand that I will be subject to initial and ongoing assessments including those focused on, but not limited to, psychiatric, emotional, intellectual, physical, neurological, educational, vocational and substance abuse subject matter, including urinalysis and breathalyzer testing.

I understand that my records are protected by federal law and regulations (42 CFR Part 2). Violation of the Federal law and regulations by the program is a crime. Suspected violations may be reported to the appropriate authorities. The Third Way Center staff may not say to any person outside of the program that you even reside at the program, or disclose any information identifying you as a patient unless under the following circumstances:

- □ Written consent is given by you
- □ Disclosure is ordered by the court
- □ Information is needed by medical personnel treating you in an emergency
- □ It is our clinical judgment that you have become harmful to yourself or others
- □ You commit or threaten to commit a crime at the program or against any person who works for the program
- □ There is suspicion of child abuse and/or neglect, and must be reported
- □ Information about you is needed for audit or program evaluation purposes

I understand that information will be reported to the Office of Behavioral Health with the Colorado Department of Human Services as required by the state. This Information will be released in compliance with the federal confidentiality statute (42 CFR). I understand the above statement regarding the assessments I will receive.

Client:_____ Date:_____
Parent/
Guardian:_____ Date:_____

Witness:_____ Date:_____

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
THIRD WAY CENTER SUBSTANCE ABUSE PROGRAM

I, _____ _____
(Name of patient) (Date of birth)

authorize Third Way Center Inc
(Name of organization making disclosure)

to disclose to Millennium Health
(Name of person or organization to receive information)

the following information:

Yes	No	
X		Name and other personal identifying information
	X	Status as a patient in alcohol and/or drug treatment
	X	Initial evaluation
X		Date of admission
	X	Assessment results and history
	X	Summary of treatment plan, progress and compliance
X		Toxicology test results
	X	Date of discharge, discharge status and discharge plan
X		Other Medicaid number

The purpose of the disclosure authorized in this is to: release name and Medicaid number for billing purposes for fluid samples sent to the laboratory for analysis

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: discharge from Third Way Center
(Specification of the date, event or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I have been offered a copy of this form.

_____ _____
(Signature of Patient) (Date)

_____ _____
(Signature of Parent/Legal Guardian) (Date)

_____ _____
(Signature of Witness) (Date)

Recreational Activities Program
RELEASE OF LIABILITY

Third Way Center recreation involves a variety of activities that may include warm-ups, games, group initiative problems, hiking, team sports, bicycle riding, swimming, supervised field trips, low challenge ropes course elements, and other rigorous physical adventure activities. The level of participation in a program activity is at all times completely up to the resident's choice; yet there is a risk which must be assumed by each participant that he or she may suffer physical injury or disability.

Third Way Center and its staff take all reasonable precautions to ensure you a very safe and enjoyable outdoor experience. You have been given an overview of the program you are about to undertake, and you will be informed of specific safety rules and regulations that you will be expected to follow. Parts of the experience, by their nature, can be physically demanding and include varying levels of stress and anxiety, not all of which can be foreseen.

Every resident participating in Third Way Center's recreation is encouraged to carry his or her own health/accident insurance coverage. Third Way Center does not offer any medical insurance to you, the resident, and makes no claims to do so.

RELEASE OF LIABILITY

I, the undersigned client, parent or guardian, authorizes the staff of Third Way Center to include such client in organized therapeutic activities and outings, under the supervision of Third Way Center staff. I understand that parts of Third Way Center recreation may be physically demanding. I affirm that I do not have any medical limitations, disclosed or undisclosed, that might endanger my health or that of other participants. I am presently under a physician's care and understand that I will require a physician's order prior to participation. I recognize the inherent risk of injury in Third Way Center's activities. I understand and acknowledge that Third Way Center does not offer medical insurance to protect against such risks, makes no claims to do so and has no responsibility for any medical expenses I incur. I understand that each participant must assume the risk of injury and any related financial responsibility that could result from participation in any of these activities. I agree to assume such risks and such financial responsibility. I release Third Way Center, its staff members, and Board of Directors from all liability for any injury to me from participation in Third Way Center's recreation or activities.

_____ _____

Participant's Signature (if 15 years or older) **Date**

_____ _____

Parent/Legal Guardian's Signature **Date**
(Required for participants 17 years of age and younger)

_____ _____

Home Phone Number **Business Phone Number**

NOTE: For 15 to 17 year old participants, both the consent of the participant and the participant's guardian should be obtained.

THIRD WAY CENTER

RESIDENT'S RESPONSIBILITIES

The staff of Third Way Center has the responsibility of respecting your rights and providing the best of care and treatment possible. As the resident, you also have responsibilities to assist staff in the accomplishment of these objectives. The following are responsibilities of all residents who receive care at Third Way Center.

1. You have the responsibility to provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters related to your health. Additionally, unexpected changes in your condition should be reported to those involved in your care. As a patient, you are responsible for making it known whether you clearly understand a contemplated course of action and what is expected of you.

2. You responsible for following the treatment plan recommended by the Clinical staff primarily responsible for your care. This may include following the instructions of Third Way Center staff as they carry out the coordinated plan of care and implement the applicable Third Way Center rules and regulations.

3. You are responsible for your actions if you refuse treatment or if you do not follow the recommended plan of care that has been developed for you. If you do not follow staff instructions, or Third Way Center policies, you are responsible for the consequences.

4. You are responsible for following Third Way rules and regulations affecting client care and conduct. Please keep appointments scheduled with your Clinical Staff or Third Way Center, or cancel them in advance if necessary.

5. You are responsible for being considerate of the rights of other clients and Third Way personnel. We ask for assistance in controlling noise, smoking, and the number of visitors you have. Just as you expect your property to be respected, please respect the property of other persons and Third Way. We also ask that you respect the privacy of others and not disclose names or any identifying information of other clients while you are here or after you leave Third Way Center.

ACKNOWLEDGEMENT OF RESPONSIBILITIES

My responsibilities as a resident of Third Way Center have been reviewed with me. I have received a copy of these responsibilities.

_____ _____

Resident's Signature Date

(Required for residents 18 years and older and voluntary residents 15 years and older).

_____ _____

Parent/Legal Guardian's Signature Date

(Required for residents 17 years of age and younger)

Relationship to Resident _____

_____ _____

Signature/Title of Third Way Witness Date

AGREEMENT AND RELEASE OF RESPONSIBILITY
PASSES AND TRIAL VISITS

This is to certify that I, _____ , or (if minor), Mother/Father/Legal Guardian
(Name of Parent or Guardian)

of _____ , a client of Third Way Center, a Residential Child Care Facility (RCCF),
(Client Name)
hereby releases the attending physician and Third Way Center from all responsibility for any illness or accident that might occur to the client, due to any cause, while he/she is away from Third Way Center premises on an approved Therapeutic Trial Visit or while on pass unaccompanied by Third Way Center staff. In consideration of the value to the client of such treatment, the undersigned hereby agrees to indemnify and hold harmless Third Way Center, its medical staff, its employees and its agents from all claims, costs, and losses incurred as a result of or in connection with any act of the patient while on leave from Third Way Center.

_____ _____
Parent/Guardian's Signature (or client if 18 or over) Date

VISITATION AGREEMENT

I hereby agree that I, _____ will abide by the following rules when visiting Third Way Center Lowry.

A "visit" is defined as any contact with Lowry Campus. This includes personal visits, professional visits, or therapeutic sessions.

I further agree that this contract holds true for any other person who might accompany me when visiting Third Way Center Lowry Campus.

- Please coordinate all visits with staff
- No lighters or matches
- No cigarettes or tobacco
- No drugs or alcohol
- Personal items to be given to the resident must be approved by staff
- We ask that all visitors respect the wholesome nutritional plan offered at Lowry and bring food and beverages that meet the nutritional guidelines of this plan. Please consult with staff if you have any questions about this.

I understand that by signing this agreement I am responsible for myself and any other person that accompanies me onto Third Way Center property.

Provisions: _____

_____

_____ _____

Resident Signature Date

_____ _____

Signature of Parent or Guardian Date

Once fully completed, please send to the following contacts based on client placement:

LOWRY

Please email Keri at kolson-larsen@thirdwaycenter.org

YORK

Please email Brianne at bmaldonado@thirdwaycenter.org

PONTIAC

Please email Julia at jeickhoff@thirdwaycenter.org

BANNOCK

Please email Barb at bbond@thirdwaycenter.org

LINCOLN and NEXT STEPS

Please email Kathleen at ksutherland@thirdwaycenter.org

*If unsure, please Amber Lacy at alacy@thirdwaycenter.org