

**Please do not fill out the following documents unless you have already scheduled an appointment.  
If you would like to make an appointment, please call our office at (702)258-5855.**

**If your call goes unanswered, please leave a voice message with your name and phone number, and we will get back to you as soon as possible.**

**Thank you.**

## **COVID-19 ADAPTIONS:**

- **FACT's Covid-19 Adaptations are subject to change based the agency's discretion**
- At this time ALL visitors at FACT will be required to wear a face covering/mask. FACT will not be providing masks.
- FACT encourages all visitors to wash their hands or use hand sanitizer immediately upon entering the office.
- Any clients who show symptoms of being sick (coughing, runny nose, sneezing, congestion, fever, watery eyes, etc.) will be asked to stay home and will not be permitted in the office.

**No complete los siguientes documentos a menos que ya haya programado una cita.  
Si desea hacer una cita, llame a nuestra oficina al (702) 258-5855.**

**Si su llamada no recibe respuesta, deje un mensaje de voz con su nombre y número de teléfono, y nos comunicaremos con usted lo antes posible.**

**Gracias.**

## **ADAPTACIONES COVID-19**

- **Las adaptaciones de Covid-19 para FACT están sujetas a cambiossegún el discreción de la agencia**
- En este momento, TODOS los visitantes de FACT deberán usar unamascarilla o una cubierta facial. FACT no proporcionará máscaras.
- FACT alienta a todos los visitantes a lavarse las manos o usar desinfectante de manos inmediatamente después de ingresar a laoficina.
- A cualquier cliente que muestre síntomas de estar enfermo (tos, secreción nasal, estornudos, congestión, fiebre, ojos llorosos, etc.) sele pedirá que se quede en casa y no se le permitirá ingresar a la oficina.

## FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA

8080 W. Sahara Ave., Suite D. Las Vegas, Nevada 89117

Phone: (702) 258-5855 Fax: (702) 258-9767

### ASO INTAKE FORM

Date	New Client _____ Returning Client _____	First and Last Name		
Date of Birth	Age	Gender	Preferred Pronoun	Employer and Occupation
Street Address	City	State	Zip Code	Phone Number

Race/Ethnicity  
 \_\_\_ Caucasian \_\_\_ African American \_\_\_ Latino/Hispanic \_\_\_ Asian/Pacific Islander \_\_\_ American Indian/Alaska Native \_\_\_ Multiracial

Marital Status Single _____ Married _____ Divorced _____ Widowed _____	Relationship History: List all past marriages and major/long-term relationships			
Highest Level of Education	Name of Partner	Length or Dates of Relationship	Married _____ Living Together _____ Neither _____	Married _____ Living Together _____ Neither _____
			Married _____ Living Together _____ Neither _____	Married _____ Living Together _____ Neither _____

PSI/Investigation Report Submitted on: \_\_\_\_\_  
 Projected Probation/Parole Expiration Date: \_\_\_\_\_ Were you incarcerated for offense? (Yes/No) \_\_\_\_\_ If yes, how long? \_\_\_\_\_  
 Tier Level: (circle) Tier 1 Tier 2 Tier 3 How did you plead? (circle one) Guilty Not Guilty Alford Plea  
 Restrictions While on Probation: (example: Cannot be around minors without supervision, supervised visits with biological children, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_

Please Describe Nature of the Offense: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Household Information

(Includes: Immediate Family, Half/Step-Siblings, live-in Partners, Roomates, and Non-Relatives)

Name:	Age	Relationship	Living In Household? (Yes/No)

Referral Source	Criminal History		
PO's Name:	Crime	Date	Outcome
Contact Number:			
Email:			
<b>Child Protective Services</b>			
Circle one: Past Present	Report #		
Caseworkers Name	Date Reported		
Case Plan:			

### Treatment History

Have you ever participated in any type of therapy in the past?  
 If yes, what type of treatment was it?  
 What was the reason for treatment?  
 Describe your experience with previous treatment?

**Substance Abuse History:** List any and all past substance abuse related information, including choice of substances and previous treatment.  
 \_\_\_\_\_  
 \_\_\_\_\_

**Additional Information:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



# FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA

## PARENTAL/GUARDIAN NOTIFICATION OF TREATMENT GUIDELINES

I understand that by signing this Parental/Guardian Notification of Treatment Guidelines form I am giving my consent for minor child, \_\_\_\_\_ (“Child”), to receive clinical mental health therapy at Family and Child Treatment (FACT). I certify that I am a parent and/or legal guardian of Child, and hereby consent for Child to receive treatment at FACT.

I understand that FACT and its clinical therapist staff do not conduct investigations, provide custody visitation evaluations, or make recommendations to any court. FACT strictly offers mental health services for children and their families who have been impacted by abuse, and the services are provided as deemed necessary by the treatment team. If you are in need of custody or visitation evaluation or any type of recommendations to be made to any court regarding Child, FACT can provide you with a copy of the Eighth Judicial District Court, Family Division, and Outsource Provider Directory. Please be advised that FACT and its clinical staff do not bear any responsibility or liability for any and all outcomes if you choose to contact and utilize any providers named on this list.

If you have joint legal custody of child, it is your responsibility to inform the non-signatory legal parent(s) and/or guardian(s) of Child’s medical treatment at FACT. FACT does not assume the liability of informing the non-signatory legal parent(s) and/or Guardian(s) of Child’s treatment at FACT. You shall indemnify and hold FACT harmless from and against any and all claims arising from the non-signatory legal parent(s) and/or guardian(s) violations of his/her right to know of your child’s treatment at FACT including, but not limited to, all damages, costs, attorney’s fees, expenses, and liabilities arising from your failure to inform the non-signatory parent(s) and/or guardian(s) of Child’s treatment at FACT.

Please be aware that Child’s legal parent(s) and guardian(s) are entitled to access Child’s medical records and, upon proper identification and documentation, FACT will release with state and federal regulations and/or a court order signed by a judge.

If there is a dispute between you and Child’s non-signatory parent(s) and/or guardians(s) as to Child’s treatment at FACT, the dispute must be settled by you and Child’s non-signatory parent(s) and/or guardian(s) in writing and provided to FACT. If you and Child’s non-signatory parent(s) and/or guardian(s) cannot agree to Child’s treatment at FACT, you may have a court resolve the issue. FACT will abide by any valid Court Order regarding Child’s treatment at FACT. FACT may decline to treat child until such disputes are finally resolved, unless imminent bodily harm to Child and/or others would result from FACT’s refusal to treat Child and/or Child is in danger or suffering a serious health hazard if FACT’s services are not provided to Child.

FACT encourages all parent(s) and guardians(s) to be an active part of Child’s treatment, if it is in the best and safest interests of Child and contact with all parent(s) and guardian(s) is deemed legally appropriate. All parent(s) guardian(s) are encouraged to bring Child to therapy and each FACT therapist will designate 10 to 15 minutes before or after each session to update you on the progress and/or concerns associated with Child. The FACT therapist **will not** be responsible for contacting the absent parent(s) and/or guardian(s) with Child’s treatment update. If Child’s parent(s) and/or guardian(s) are unable to attend any or all sessions, it is the absent parent(s) and/or guardian(s) responsibility to contact Child’s FACT therapist directly to discuss any alternative means of being involved in Child’s treatment.

**Regarding access to the records of an un-emancipated minor.** The agency is able to release Protected health information to a client’s personal representative, who is defined as, an individual who is a parent, guardian, or other person acting in the place of a parent and who have documented authority to act on behalf of the client. However, in the following circumstances **FACT is not required to treat a person as a personal representative;**

1. When a parent, guardian, or other person who has the authority to act in place of the parent and they enter into an agreement of confidentiality between a covered health care provider and the minor with respect to such health care service.
2. FACT has a reasonable belief that the individual has been or may be subjected to domestic violence, abuse, or neglect by such person; or
3. Treating such person as the personal representative could endanger the individual; and FACT, in the exercise of professional judgment, decides that it is not in the best interest of the individual to treat the person as the individual’s personal representative.

**I have read the foregoing Parental/Guardian Notification of Treatment Guidelines understanding, acknowledging, and agreeing to all of its terms. I acknowledge that this is a legally binding agreement.**

\_\_\_\_\_  
Signature of Client or Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of FACT Representative

\_\_\_\_\_  
Date

# **FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA**

## **PRIVACY POLICY FOR TREATMENT OF MINORS/PARENTS OF MINORS**

It is the policy at FACT to respect client/therapist confidentiality for all of our clients regardless of client age. Therapy is most effective when client privacy is respected by all parties. Clients are able to be the most honest and open in their sessions if they are confident in their rights to confidentiality.

It is the policy at FACT to maintain confidentiality for child and adolescent clients. By signing below, you are stating that you understand and agree to FACT maintaining your child's right to confidentiality, unless otherwise specified in writing by a legal guardian in advance of treatment. This includes (but is not limited to) information about drug use, self-harm, sexual activity, pregnancy, pregnancy termination, dating, social activities, and school participation.

The exceptions to this confidentiality will fall under mandated reporting requirements. This includes suicidal ideation, intent, or plan, and child abuse that is ongoing or has not previously been reported. In the event that any of these exceptions is disclosed to a therapist at FACT, the therapist will inform the parents and/or the required authorities as mandated by the state of Nevada.

If you have any questions or concerns, please speak with a FACT representative directly.

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<b>Signature of Client or Parent/Guardian</b>	<b>Date</b>	<b>Signature of FACT Representative</b>	<b>Date</b>
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# FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA

## NOTICE OF PRIVACY PRACTICE

### Please Review This Notice Carefully

This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website ([www.factsnv.org](http://www.factsnv.org)).

**Regarding access to the records of an un-emancipated minor.** The agency is able to release PHI to a client's personal representative, who is defined as, an individual who is a parent, guardian, or other person acting in the place of a parent and who have documented authority to act on behalf of the client. However, in the following circumstances FACT **will not** treat a person as a personal representative;

1. When a parent, guardian, or other person who has the authority to act in place of the parent and they enter into an agreement of confidentiality between a covered health care provider and the minor with respect to such health care service.
2. FACT has a reasonable belief that the individual has been or may be subjected to domestic violence, abuse, or neglect by such person; or
3. Treating such person as the personal representative could endanger the individual; and FACT, in the exercise of professional judgment, decides that it is not in the best interest of the individual to treat the person as the individual's personal representative.

### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose protected health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Treatment, Care or Services.** We may use protected health information about you to provide you with counseling treatment or services. We may disclose information about you to therapists, psychologists and, interns who are in employed by this agency. For example, any staff member may help schedule your appointment, the bookkeeper will process your billing or insurance claims and therapists and supervisors may discuss and strategize how to best meet your needs.

**For Payment.** We may use and disclose protected health information about you so that the treatment and services you receive at the agency may be billed to and payment may be collected from you, an insurance company or a third party.

**For Agency Operations.** We may use and disclose protected health information about you for agency operations. These uses and disclosures are necessary to run the agency and make sure that all of our clients receive quality care. For example, we may use information to review our treatment and services and to evaluate the performance of our staff in caring for you or your children. We may also disclose information to counselors, interns, social workers and other agency personnel for review and learning purposes. **RESEARCH-All clients who are seeking treatment for child sexual abuse, your information will be kept confidential and will not be released for research purposes. This does not apply to offender services.**

**Appointment Reminders.** We may use and disclose protected health information to contact you as a reminder that you have an appointment for treatment or care at the agency.

**Treatment or Program Alternatives.** We may use and disclose protected health information to tell you about or recommend possible treatment or program options or alternatives that may be of interest to you.

**As Required by Law.** We will disclose protected health information about you when required to do so by federal, state or local law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

**Public Health Risks.** We may disclose protected health information about you for public health activities. These activities generally include the following: To prevent or control injury or disability; to report births and deaths; To report the abuse or neglect of children, elders and dependent adults.

**Health Oversight Activities.** We may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a judge's order.

**Law Enforcement.** We may release protected health information if asked to do so by a law enforcement official: However, Substance abuse treatment records cannot be released without a judge's order, all other records may be disclosed. In response to a court order, subpoena, warrant, summons, or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct in the agency; and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

**With Authorization:** Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. You may refuse to sign or revoke your authorization at any time. If you have been referred by the courts and your treatment progress and all other applicable information is required, your decision to revoke could lead to unsuccessful treatment discharge.

### **YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding protected health information we maintain about you:

**Right to Inspect and Copy.** You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes billing records. To inspect and copy information that may be used to make decisions about you, you must submit your request in writing to the Office Staff. 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.

**However, we may deny your request to inspect psychotherapy notes.** **Psychotherapy notes** are defined as notes recorded (in any medium) by a health care provider who is a mental health care professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's medical record. Other portions of the record may be released. If you are denied access to this information, you may request in writing that the denial be reviewed. Another licensed professional chosen by the agency will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend.** If you feel that protected health 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 the agency.

To request an amendment, your request must be made in writing and submitted to the Office Staff. 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 protected health information kept by or for the agency; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we make of protected health information about you other than our own uses for treatment, payment and agency operations, as those functions are described above. This is available to records up to six years old. You must submit your request in writing to the office staff and must identify a specific time period. 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.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or agency operations. You also have the right to request a limit on the information we disclose about you to someone who is involved in your case or the payment for your case, like a family member or friend. For example, you could ask that we not use or disclose information about appointment times.

**We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Office Staff. 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 spouse.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about agency matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Office Staff. We will not ask you the reason for the request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a 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. You may obtain a copy of this notice from office staff or from our website, [www.factsnv.org](http://www.factsnv.org).

### **COMPLAINTS**

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Executive Director, Heather Campa, at Family and Child Treatment of Southern Nevada, 8080 West Sahara Ave., Suite D, Las Vegas, NV 89117, Phone: (702) 258-5855 ext. 232 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D. C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

**I hereby acknowledge that I have received and have been given an opportunity to read a copy of FACT's Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can discuss with my therapist.**

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

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

\_\_\_\_\_  
Signature of Client or Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of FACT Representative

\_\_\_\_\_  
Date

# FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA

## NON-DISCRIMINATION POLICY

It is the continuing policy and commitment of FACT to provide equal opportunity for job applicants, to provide equal opportunity for advancement of employees, and to administer these policies in a manner that does not discriminate against any person because of race, religion, color, sex, sexual orientation, age, marital status, national origin, physical disability, or veteran status.

This policy applies to all agency operations and includes all types of employment practices such as but not limited to: Recruiting, hiring, training, wages, compensation, assignments, working conditions, promotions, reduction in work force, employee treatment, and all other terms and privileges of employment. Additionally, FACT will not discriminate in its delivery of services to clients because of race, religion, color, sex, sexual orientation, age, marital status, national origin, physical disability, or veteran status.

This document establishes written procedures as required by the **Nevada Office of the Attorney General (OAG) Grants Unit**, as sub-recipients, to follow when a complaint is received alleging discrimination from clients, customers, program participants, or consumers or of a sub-recipient of funding from the U.S. Department of Justice.

All individuals have the right to participate in programs and activities regardless of race, color, national origin, sex, religion, disability, and age. These classes are protected from discrimination in employment and in the provision of services. In addition to these, sub-recipients of grants under the Violence Against Women Act (VAWA) of 1994, as amended, are prohibited from discriminating on the basis of sexual orientation or gender identity.

### **FACT must comply with the nondiscrimination provisions within the applicable DOJ program statutes, which may include the following:**

1. Omnibus Crime Control and Safe Streets Act (Safe Streets Act) of 1968, as amended, 34 U.S.C. §§ 10228(c) and 10221(a), and the DOJ implementing regulations, 28 CFR part 42, subparts D (prohibiting discrimination in programs funded under the statute, both in employment and in the delivery of services or benefits, based on race, color, national origin, sex, and religion) and E (requiring certain DOJ-funded programs subject to the administrative provisions of the statute to prepare, maintain, and submit an Equal Employment Opportunity Plan (EEO));
2. Juvenile Justice and Delinquency Prevention Act (JJDP) of 1974, as amended, 34 U.S.C. § 11182(b), and the DOJ implementing regulations, 28 CFR §§31.202, .403 and part 42, subpart D (prohibiting discrimination in programs funded under the statute, both in employment and the delivery of services or benefits, based on race, color, national origin, sex, and religion);
3. Victims of Crime Act (VOCA) of 1984, as amended, 34 U.S.C. § 20110(e) and the regulation implementing the Victim of Crime Act Victim Assistance Program, 28 CFR §94.114 (prohibiting discrimination in programs funded under the statute, both in employment and in the delivery of services or benefits, based on race, color, national origin, sex, religion, and disability); and
4. Violence Against Women Act (VAWA) of 1994, as amended, 34 U.S.C. § 12291(b)(13) (prohibiting discrimination in programs either funded under the statute or administered by the Office on Violence Against Women, both in employment and in the delivery of services or benefits, based on actual or perceived race, color, national origin, sex, religion, disability, sexual orientation and gender identity).

**These laws prohibit agencies from retaliating against an individual for taking action or participating in action to secure rights protected by these laws.**

### **Written Procedures to Address Complaints Filed Against Sub-Recipients:**

1. Complaints from any source are to be submitted on the Written Complaint Statement of Concern/Complaint with Grant Programs Form to the OAG Grants Manager.
2. The complaints are to be submitted to:  
Debbie Tanaka, Grants Manager Office of the Attorney General 100 North Carson Street  
Carson City, NV 89701  
Or [dtanaka@ag.nv.gov](mailto:dtanaka@ag.nv.gov)
3. The OAG Grants Manager will review any and all complaints in an objective and impartial manner and provide the complainant with written acknowledgement of the complaint and how correspondence will be administered throughout the investigation as well as an explanation of how the complaint will be investigated upon and resolved.
4. Any person who submits a complaint of impermissible discrimination is notified promptly that a complaint also may be filed with the Office of Justice Programs' (OJP) Office for Civil Rights, by submitting a written complaint to the following address  
**Office for Civil Rights Office of Justice Programs, U.S. Department of Justice, 810 Seventh Street N.W. Washington, DC 2053**

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Signature of Client or Parent/Guardian

Date

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Signature of FACT Representative

Date



**FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA**

**AUDIO-VISUAL CONSENT FORM**

**Client's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Name of Parent or Guardian: \_\_\_\_\_

Address of Parent or Guardian: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Use of Audio-Visual Recordings**

Family and Child Treatment (FACT) is considered a **training facility due to the close supervision of students and licensed interns at this site.** As a result, to provide quality services, video and/or audio recordings, or both, may be taken of the counseling sessions. **These audio-visual materials are used as part of the supervisory process.** The clients and FACT staff may review these materials as a means for exploring client and therapist interactions and therapy interventions to improve the quality of services provided and to monitor therapist development. **All audio and/or videotapes will be kept confidential and will be destroyed following the client's involvement in the program upon the family's or client's request.** Some audio and/or video recordings of counseling sessions may also be used for educational and research purposes with the client's identity concealed and only with their written permission. The audio and/or videotapes will not be used for any other purposes without the family's or client's written permission on a separate release form.

\_\_\_\_\_  
**Signature of Client or Parent/Guardian                      Date              Signature of FACT Representative              Date**

## **FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA ELECTRONICS AND INTERNET POLICY**

Computers, tablets, cellular phones, and various other internet-based devices are utilized at FACT. These devices enable FACT to utilize internet-based platforms, such as telehealth applications, social media, email, and a variety of other forms of communication, in order to provide resources to our clients. The policies for each are outlined below. Social media includes online communication that seek and share information, provide professional services, and send and receive information. Examples include emails, texting, blogging, Doxy.me, Facebook, Instagram, Pinterest, and Twitter. Please note that social media and internet-based platforms may not protect your privacy and are considered public communication. The use of it to provide services is only done with your approval.

### **Search Engines**

Search engines are not used to seek information about you. A rare exception would be during a crisis when there is reason to suspect that a client may be in danger to themselves or others and all other resources have been exhausted. Should this ever occur, documentation will be added to the clients clinical record and discuss it with the client at the next session. If you should use search engines to seek information regarding clinicians, we recommend the client discuss any concerns that they may have about the therapist at the very next session.

**Client Initials** \_\_\_\_\_

### **Texting/Cell Phones**

It is FACT's position that clients and clinicians should not utilize cell phones or text messaging for treatment purposes. This type of communication can compromise confidentiality. However, FACT acknowledges that there may be unique circumstances that require the use of cell phones or text messaging. The use of cell phones or text messaging may be established on a case-by-case basis between client and clinician, only if no other form of communication is available or on a short-term, as-needed basis. In these unique situations, clinicians are discouraged from providing clients with personal cell phone numbers and are encouraged to provide a Google-Voice number to be utilized for work related purposes. Phone calls and text messages received will be documented in the clients clinical record.

**Client Initials** \_\_\_\_\_

### **Emails**

Emails should only be utilized for scheduling or cancelling an appointment and it must be from a client's personal email account only. Do not email content related to therapy sessions beyond scheduling because such communication may not be secure nor confidential. Clients should also avoid using emails for emergencies or when in crisis because clinicians have limited business hours in which they are required to check work related emails. Emails received from you and sent to you become a part of your clinical record.

**Client Initials** \_\_\_\_\_

### **Telehealth Applications**

Telehealth is a rapidly expanding area inside mental health. Telehealth's growing popularity can be attributed to the fundamental benefits it brings to both providers and clients. Due to the nature of treatment provided at FACT, telehealth options are not available as a long-term/primary method of treatment. Telehealth should only be utilized on a temporary and as-needed basis. Currently, *Doxy.me*, is the only platform approved to be used with FACT clients. Information about Doxy.me can be found on their site, Doxy.me.

**Client Initials** \_\_\_\_\_

### **Social Media**

Friends or contact requests from current or former clients on social networking sites may compromise confidentiality and therapeutic relationships and are not accepted. There will be no friending via social networking sites such as Facebook, Instagram, Pinterest, LinkedIn, etc. If there is content a client wishes to share with their clinician from their personal site, a client should bring it to their next session for discussion.

Clinicians do not follow current clients or former clients on Facebook, Instagram, Pinterest, Twitter, blogs, or any other social media platform. Doing so may negatively influence the therapeutic relationship. FACT may sometimes publish content on the official FACT agency website and official FACT social media platforms. However, there is no expectation for any client to follow FACT on social media.

**Client Initials** \_\_\_\_\_

**Location-Based Services**

There are privacy concerns related to location based services on a mobile phone. If a client has GPS tracking or a location-based device on a mobile phone, it may compromise a clients privacy and provide a clue that you are a therapy client due to your regular check-ins. Please be aware of your devices and any applicable GPS tracking capabilities, and make note to turn them off in order to protect your privacy.

**Client Initials** \_\_\_\_\_

**Separate Accounts**

FACT has professional social media accounts which are used solely for professional matters, public awareness and education, and information regarding agency practice. Client information will not be shared on any account nor will clinicians/staff have an online relationship with clients on any FACT professional sites. Clients are not expected to respond or comment on anything that the agency posts. Clinicians will not respond to any comments clients may have online. If a client has a concern about anything the agency posts, the client should make their clinician aware of it during their next session so that it can be discussed. Clinicians have personal accounts which are separate from the FACT accounts and are used for non-professional activities. No information about clients will be posted on clinicians personal or professional accounts.

**Client Initials** \_\_\_\_\_

If you have any questions about FACT’s social media policy, please speak with a clinician directly. Should there be any changes to this policy, clinicians will inform clients as soon as reasonably possible.

\_\_\_\_\_  
**Client or Parent/Guardian Signature**                      **Date**                      \_\_\_\_\_  
**Signature of FACT Representative**                      **Date**

**FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA**

8080 W Sahara Ave, Suite D, Las Vegas, NV 89117

Phone: (702) 258-5855 Fax: (702) 258-9767

**CLIENT AUTHORIZATION TO RELEASE INFORMATION FORM**

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

**Date of Birth:** \_\_\_\_\_

I hereby authorize Family and Child Treatment (FACT) of Southern Nevada to release and/or receive information to/from:

**Organization: Adult Parole & Probation**

Individual Name/Title: \_\_\_\_\_

Address: 218-5 E Bonanza Road. Las Vegas, Nevada 89101

Phone: (702) 486-3001 ext. \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_@clarkcountynv.gov

**Specific information to be released:**

- |   |   |  |
|---|---|--|
| <input checked="" type="checkbox"/> Diagnosis               | <input checked="" type="checkbox"/> Presence/Participation in Treatment | <input checked="" type="checkbox"/> Termination Summary      |
| <input checked="" type="checkbox"/> Psychiatric Evaluation  | <input checked="" type="checkbox"/> Demographic Information             | <input checked="" type="checkbox"/> Current Treatment Update |
| <input checked="" type="checkbox"/> Psychosocial Assessment | <input checked="" type="checkbox"/> Psychological Evaluation            | <input checked="" type="checkbox"/> Progress in Treatment    |
| <input checked="" type="checkbox"/> Treatment Plan/Summary  | <input checked="" type="checkbox"/> Current Medications                 | <input checked="" type="checkbox"/> ABEL Results             |

The purpose of this information is to improve assessment and treatment planning, share information relevant to treatment, coordinate treatment services, promote community safety and maintain continuity of care.

If other purpose, please specify: \_\_\_\_\_.

I understand that I have a right to revoke or limit this authorization by sending written notification to my therapist at FACT. However, I further understand that if I choose to revoke or limit my consent and I am court mandated to receive services, FACT may discharge me as it impairs their ability to effectively treat me.

This consent expires: (PICK ONLY ONE)

- 30 days after the completion of treatment,
- \_\_\_\_\_ On the following date \_\_\_\_\_,
- \_\_\_\_\_ Or the following event \_\_\_\_\_.

NOTE: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically. It is FACT policy that psychotherapy notes are not released to any party, unless required by subpoena or court order.

TO PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose FOR CLIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2 I, the undersigned, also understand that a copy of this signed authorization form is as acceptable as the original.

\_\_\_\_\_  
**Client or Parent/Guardian Signature** **Date**

\_\_\_\_\_  
**Signature of FACT Representative** **Date**

# FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA

8080 W. Sahara Ave., Suite D. Las Vegas, Nevada 89117

Phone: (702) 258-5855 Fax: (702) 258-9767

## POLYGRAPH EXAMINATION REQUIREMENT

I understand that participation in the Adult Sex Offender Treatment Program at Family and Child Treatment (FACT) involves taking a polygraph examination. The polygraph examination is to be completed prior to the end of any Adult Level I (12 week) course and I am responsible for the cost of this test. Information about my offense and myself will be provided to the polygraph examiner prior totaking the polygraph.

I understand that treatment cannot be effective if I am not truthful. I further understand that the polygraph test in sex offender treatment at FACT will be used to verify my truthfulness about mysexual history, as well as to validate if I am complying with the conditions of my treatment.

The results of any polygraph test I complete while in treatment at FACT will be shared with my Probation/ Parole Officer. I understand that my Probation/ Parole Officer may take action againstme based on the result of my polygraph test.

I understand that I must pass the polygraph test in order to be considered for movement from Level Ito Level II. I will not be considered for movement to Level II if I make a full admission of my sexual history *after* failing a polygraph test. It is the position of The Association for the Treatment of Sexual Abusers (ATSA) that "community-based treatment is not appropriate for a client who continues to demonstrate complete denial (ATSA, 1997)." FACT abides by ATSA standards and has adopted the policy not to treat deniers for longer than 12 weeks. This policy is based on the ethical reasons thereare no concrete treatment goals to work on when a person continues to deny their behavior.

Therefore, I understand that if I fail a polygraph test, and continue to deny responsibility for my offense, I will be terminated from the Adult Sex Offender Treatment Program at FACT.

\_\_\_\_\_  
**Signature of Client**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of FACT Representative**

\_\_\_\_\_  
**Date**

# FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA

8080 W. Sahara Ave., Suite D. Las Vegas, Nevada 89117

Phone: (702) 258-5855 Fax: (702) 258-9767

## ADULT OFFENDER TREATMENT CONTRACT

Date: \_\_\_\_\_ Program Start Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### GENERAL PROGRAM CONDITIONS:

1. I understand that by signing this agreement I am giving my voluntary consent to participate in the Sexual Offender Treatment Program at FACT.
2. I understand that my progress in treatment will be measured by my:
  - a. Attendance
  - b. Weekly participation in treatment
  - c. Compliance with the treatment contract
  - d. Openness in talking about my sexually abusive behavior
  - e. Completion of homework assignments
  - f. Keeping fees current
3. I have read the Notices of Privacy Practices and understand the exceptions involving court- mandated treatment. I understand that a weekly progress report will be sent to my appropriate referring agency in regard to my attendance, participation and treatment progress, etc.
4. I understand that I may at any time, withdraw my authorization to release information. I also understand that if I withdraw my authorization to release information to the courts/Probation- Parole, I will be terminated because it will prevent FACT from effectively treating me.
5. FEES:
  - a. \$50 - Initial Intake fee. Paid at first initial appointment prior to group.
  - b. \$25 - Weekly group fee. Paid prior to group.
  - c. \$25 - Scheduled meetings with therapist outside of group to:
    - i. Discuss with therapist contract non-compliance issues.
    - ii. Meet with probation/parole officer.
    - iii. Individual therapy sessions.
  - d. \$20 - \$400 - Psychological or psychophysiological testing requested by therapist. This is not typical in treatment but may be required if clinically necessary.
  - e. \$100 per hour- If I or my attorney request FACT to testify in court or request participation in court proceedings. Charge is portal to portal.
  - f. \$250-\$275- Polygraph paid to independent polygraph examiner.
  - g. You could be terminated for nonpayment of fees.
  - h. If FACT raises fees, you will be notified 14 days in advance.
6. I understand there is no funding to supplement sex offender treatment. You alone are responsible for your offense and your treatment. You may pay fees in advance but you may not get behind. If you fall behind in your fees your probation/parole officer or referring agency is immediately notified. If you become habitually delinquent, you will possibly be removed from your main treatment program and placed in an accountability group where you will work on budgeting and other related topics. You will be permitted to return to your main treatment program once you have paid your own fees.
7. I understand that I am required to introduce myself to any new group member, staff members, or observer by going through the formal "introduction exercise" where each group member discloses:
  - a. First name
  - b. The number of victims I have had
  - c. What I did to my victim(s) using proper terms. I fondled my daughter using my hand, touching her vagina under her clothes.
8. I agree to complete all treatment homework assignments within the designated time frame as instructed by my group therapist.

9. I agree that unless approved by my FACT therapist I should not participate in any other type of treatment while in FACT. I will inform FACT if I have other court ordered treatment.
10. I agree, understand to pay for, and participate in additional treatment session if my therapist believes it is clinically necessary.
11. I understand, agree to pay for, and participate in at least one polygraph to help determine the number of victims of my sexual abuse and the extent of that abuse. If I passed the polygraph, I understand I will be moved into the next level of treatment. If I fail a polygraph, I understand that I may be required to repeat a part of a previous level, repeat an entire level, or I may be referred back to parole-probation, or the referring agency, because FACT is unable to determine the extent of my sexually abusive behavior. If I refuse a polygraph, I understand I will be immediately terminated at staff request. Therapists may require additional polygraphs as necessary or as part of the completion process.

**ATTENDANCE CONDITIONS:**

1. I will attend all treatment sessions required by FACT staff and I will be on time. I understand that if I am more than 10 minutes late, I will not be allowed to enter group, regardless of the reason, and I will receive an unexcused absence.
2. I understand that I will be given a total of 3 absences every six months. These will be defined either excused or unexcused. These absences can be used for illness, work issues, transportation issues or Parole and Probation approved vacations. Parole and Probation (or referring agency) is notified for each absence. You cannot miss more than 3 groups per level and you may only have one absence in a 30-day period. Any other absences are considered a treatment issue at which time you could be terminated or be required to repeat the level.
  - a. Excused Absence-
    - i. I am not required to pay the weekly session fee.
    - ii. I must notify my therapist at least 90 minutes before the group starts that I will be absent and why I will be absent
    - iii. I do not have more than one absence in a 30-day time period.
  - b. Unexcused Absence-
    - i. I am required to pay the session fee, even though I am absent.
    - ii. I did not contact my therapist at least 90 minutes before group.
    - iii. I have more than one absence within a 30-day period.

**EMPLOYMENT/VOLUNTEER WORK:**

1. I will notify FACT staff immediately of any changes in my employment status. I will discuss any potential changes to my employment during my group sessions well in advance of taking any new employment or volunteer position to help determine any potential risks.
2. I will not apply for, accept, or keep any job I volunteer work that involve any potential for gaining access to victims or offense situations. I will not apply for any job that is in an area where children frequent or includes contact with children as part of my regular duties.

**GENERAL BEHAVIOR CONDITIONS:**

1. I will have absolutely no contact with any victims of my sexually abusive behavior unless approved by my PO and FACT staff. I also agree I will not be in the vicinity or any location where I know my victim may be at or frequents. Having contact with victims requires a reunification agreement and is not considered until I am in level 3. I understand that contact includes physical, visual, written, and telephone contact, relaying messages through a third party and gift giving directly or indirectly. This does not include child support payments that are court ordered.
2. I will not be abusive or excessively controlling in any way towards others including my family. I will discuss in group problems I am having with changing my behavior. I understand that attempting to control others or coercing others do what I want is part of my sexually abusive behavior.
3. I agree to discuss with my therapist any thoughts or plans I may be having of suicide, harming myself or thought or plans of harming others.
4. I will not own, view, have in my possession, or use erotic materials, at any time, including but not limited to: erotic movies, 900 numbers, Internet, magazines, photographs or anything else that could be considered erotic. I will not post any profiles on dating sites or on social sites such as MySpace.
5. I will completely avoid adult entertainment, including but not limited to: massage parlors, adult bookstores, strip clubs or any form of involvement with prostitutes.
6. I understand that I am prohibited from using any alcohol, illicit drugs or prescription drugs unless I can provide a doctor's prescription in my name. I may be required to have a substance abuse evaluation and be required to submit and to treatment recommendations such as inpatient treatment, outpatient treatment or 12 step meetings. I understand this requirement would then be added as a special condition in this contract.
7. I will not have any weapons in my possession while attending FACT group meetings (including in any vehicles I drive or ride in).

8. I understand I am required to have a full time job, or be in school fulltime or a combination. I am required to pay my fees with money earned from my income. If I have a lapse of 4 weeks or more in employment or if my employment history is erratic, I understand I will be taken out of my regular treatment program and placed in the accountability group to address my issues with employment, work on changing my perceptions, and improve my employment searching skills until I have secured permanent employment. Temporary employment agency assignments will not be considered permanent employment unless it is a temp to perm job placement.
9. I will practice safe boundaries including but not limited to locking doors to bathrooms and bedrooms that I occupy, or any place where I may be unclothed or partially unclothed. I will maintain conservative dress when others are present. I will always knock on closed doors before entering and I will not use coercion or force to enter. I will respect the rights and dignity of others.
10. I understand that my victim's needs and desires come before my own in any situation or activity where there is a potential conflict.
11. I will avoid public restrooms if possible. I will never use open stalls or urinals in a public restroom. I will exit as quickly as possible if a child is present.

**GROUP SESSION BEHAVIORS:**

1. I understand I am required to actively participate in group sessions. Active participation includes; talking about my daily life, my thoughts, my behaviors, how I am applying what I am learning, asking questions of staff and other group members and presenting my assignments. I understand that active participation is the only way therapists can evaluate my progress. I understand I cannot progress if I do not participate.
2. I will use only first names when referring to my victim(s). I understand that victims are entitled to confidentiality.
3. I will not attend groups or treatment while under the influence of alcohol or drugs. I will not have in my possession any intoxicating substances or drug paraphernalia.
4. I will respect others. I will not yell at others, become verbally insulting, threatening or physically assaulting towards any FACT staff member or client whether inside or outside of the office. I understand charges will be filed against me if I assault someone connected to the FACT program.
5. I agree to discuss deviant sexual fantasies and deviant sexual urges. I understand these urges or fantasies are not uncommon and to get better I must talk about them.
6. I agree to be honest during all treatment sessions and assume full responsibility for my offenses and my behavior. I understand that being dishonest includes giving false information as well as leaving information out. I understand the importance of these principles of honesty and will make every effort to apply them in my daily life.
7. I understand that I need to be honest with my spouse, partner, and family and reveal my sexual history. I will invite my spouse or significant others to participate in planned sessions to disclose all information about my offense(s).
8. I will not disclose the identity of, or any information regarding another client to anyone outside this program unless it is to an appropriate authority in an emergency situation and therapist are not available. If I see someone in public or in a photograph that is in my treatment program, I am not to reveal how I know that person. Confidentiality is important to building trust in group.
9. I understand that I am not permitted to have social contact with other members who are in this or any other sex offender treatment program. I will discuss in group any accidental contact with other members. I may not exchange phone numbers or socialize in any way.

**RELATIONSHIPS AND DATING:**

1. I understand and agree that my dating and sexual activity must be openly discussed in group as it is related to learning healthy boundaries and how to have healthy, age appropriate relationships.
2. I will always respect my sexual partner's (or potential sexual partner's) right to say "no" to engaging in any social or sexual contact with me. I further understand that "no" includes any verbal or physical resistance.
3. I will immediately inform FACT of any change in my relationship situation (i.e., if I start or end any new relationship, plan to move in or out of living with a person, or if I plan to marry, divorce, or separate).

**CONTACT WITH CHILDREN:**

**If you have had an offense against a child, you are required to abide by the following conditions. Initial one of the following:**

**This Section DOES apply to me:** \_\_\_\_\_ **This Section DOES NOT apply to me:** \_\_\_\_\_

1. I will follow the sex offender conditions as stipulated in NRS 176A.410-416. I am to avoid locations frequented by children unless a Judge determines I can engage in these activities (FACT requires a copy of the order).
2. If I have legal permission to be with my own children, I will not take my children to movie theaters, bowling alleys, parks, birthday parties, water parks, or schools or any other location that is frequented by children without permission from FACT and my PO or a written order by a judge.
3. I will not date or live with anyone who has children in the home or who frequently interacts with children such as a parent with custody, partial custody or visitation, teachers etc.
4. If I am legally allowed to interact with children, I may be required by FACT to have an approved adult supervise my contact with authorized children in the form of a chaperone agreement.



**VIOLATING THIS CONTRACT:**

1. I understand that my probation/parole officer and/or FACT group therapist will be notified immediately of any violation of this contract. I also understand that local or state police departments may be contacted if necessary to maintain victim or community safety.
2. I understand that any violation of the conditions of this contract may be grounds for termination from the program at the discretion of FACT staff. I understand FACT may terminate my treatment for any problem behavior deemed disruptive. I may receive a termination for non-compliance or maximum benefit reached if my therapist believes it is in my and / or other clients' best interest to do so.

**SPECIAL CONDITIONS:**

Check, initial and complete only those that apply. Leave the items blank if they do not apply.

1. Substance Abuse Evaluation: I will participate and pay for a substance abuse evaluation and comply with treatment recommendations. I agree to have my evaluation and treatment compliance reports released to FACT. **Initials** \_\_\_\_\_
2. Alcohol Anonymous or Narcotics Anonymous: I will attend AA or NA meetings \_\_\_\_\_ per week and provide written verification to include the first name and telephone number of the person conducting the meeting who can verify my attendance at each meeting. **Initials** \_\_\_\_\_
3. Psychiatric Evaluation: I will participate and pay for a psychiatric evaluation and comply with treatment recommendations. I agree to have my evaluation and treatment compliance reports released to FACT. **Initials** \_\_\_\_\_
4. Gambling Evaluation: I will participate and pay for a gambling evaluation and comply with treatment recommendations. I agree to have my evaluation and treatment compliance report released to FACT. **Initials** \_\_\_\_\_

**OTHER CONDITIONS:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

I hereby enter into this treatment contract with FACT Sex Offender Treatment to allow their staff to provide me with a specialized treatment program for my sexual misconduct/behavior. I have read this contract, and I understand and acknowledge that I am required to follow all of the conditions listed above regarding my treatment and behavior. I acknowledge that I have received a copy of this treatment contract and agree to refer to it as needed.

\_\_\_\_\_  
**Signature of Client**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of FACT Representative**

\_\_\_\_\_  
**Date**

# FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA

## FINANCIAL INFORMATION FOR VICTIM SERVICES

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent Name (if Client is a minor): \_\_\_\_\_

**Family and Child Treatment of Southern Nevada (FACT) does not bill private insurance or Medicaid. All of our victim services are provided based on a sliding fee scale (see below.)**

If you/child are a victim of sexual abuse/assault & the incident occurred in Las Vegas, you/child may be qualified for no cost counseling. For determination of eligibility, you must complete & submit an application to Victim Witness Assistance Center. You must have a police event number; therefore, a police report must be filed. Please inquire within for more information. You may contact Victim Witness Assistance Center at 702-671-2525 if you have any questions.

In what city/state did the incident occur? \_\_\_\_\_

Is there a police report on file or event number?	YES	NO
Have you completed a Victim Witness application?	YES	NO
Have you/child been approved for Victim Witness?	YES	NO
Have you completed a Victims of Crime application?	YES	NO
Have you/child been approved for Victims of Crime?	YES	NO

If you have been approved for Victim Witness and/or Victims of Crime, please provide us a copy of the approval letter(s).

Please identify how services will be paid for (check all applicable boxes):

Client was a victim of a crime. Application for Victim Witness has been submitted to pay for services.

Date of Crime \_\_\_\_\_ Police Incident Number \_\_\_\_\_

Date Application Submitted \_\_\_\_\_  I have an authorization letter from Victim Witness

Client was a victim of a crime. I have not submitted an application for Victim Witness. I need assistance in completing the form or do not have a form.

Date of Crime \_\_\_\_\_ Police Incident Number \_\_\_\_\_

Date Application Submitted \_\_\_\_\_

Client has Medicaid

· Any potential clients who are currently on Medicaid (or who would qualify for Medicaid) will receive treatment at \$0 per session.

Client has other insurance. Name of insurance \_\_\_\_\_

· Potential clients who have other insurance may choose to pay their insurance copay amount per session, or may utilize the sliding fee scale listed below.

I will be paying cash

I have no resources to pay for services.

### Sliding fee scale

Family income	\$0-\$35,000	\$35,001-\$50,000	\$50,001-\$75,000
Family fee scale	\$0 per session	\$10 per session	\$25 per session

Family income	\$75,001-\$100,000	\$100,001-above
Family fee scale	\$50 per session	\$75 per session

I agree to pay \$ \_\_\_\_\_ for FACT professional services at the time rendered.

**If paying the above determined fee becomes a financial burden, or if you are unable to make your payment for any reason, please speak with your therapist. Victims will never be denied services due to inability to pay for therapy sessions.**

\_\_\_\_\_  
Signature of Client or Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of FACT Representative

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY**

**FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA**

**INTAKE REFERRAL SOURCE CODES FORM**

**Client Name:** \_\_\_\_\_ **Gender:(circle) M F Age:** \_\_\_\_\_

**\*\*\*INTAKE STAFF\*\*\***

Please circle the appropriate code for referral source, presenting issue, and ethnicity.

**REFERRAL SOURCE CODES:**

**PRESENTING ISSUES CODES:**

- 01 Criminal Justice Agencies/Courts
- 02 State or County Social Services/Welfare/CPS
- 03 Adult Mental Health
- 04 Medical Source
- 05 Self
- 06 Relative/Friend/Neighbor
- 07 District Attorney/City Attorney
- 08 Religious Source/Clergy
- 09 Police/Law Enforcement
- 10 School
- 11 Military
- 12 Drug/Alcohol Program
- 13 Unknown/Anonymous
- 14 Division of Child and Family Services
- 15 Hotline
- 16 Other Domestic Violence Programs
- 17 Other State or County Agency
- 18 Other Nonprofit Agency
- 19 SAINT/County
- 20 Clark County Department of Family Services (DFS)
- 21 Health District
- 22 Homeless Shelter
- 23 Women's Development Center
- 24 Donna's House
- 25 Rape Crisis Center
- 26 Family Mediation, Family Court
- 27 Victim Witness, District Attorney's Office
- 28 Federal, State Adult Parole and Probation
- 29 Juvenile Court, Juvenile Probation
- 30 Other Counseling Agency
- 31 Other Community Program
- 32 Private Attorney, Public Defender

- A Child Sex Abuse Victim
- B Parent of Child Sex Abuse Victim/NOP
- C Adult Molested as Child
- D Juvenile Sex Offender
- E Adult Sex Offender
- F Child Abuse/Neglect Victim
- G Rape Victim
- H Substance Abuse
- I Domestic Violence
- J Abusive Parent
- K JSO Parent
- L Secondary Victim
- M Family Abuse
- N Victim of Violent Crime
- O Sexual Assault
- P Anger Management

**Clinician's Initials** \_\_\_\_\_ **Date** \_\_\_\_\_

**ETHNICITY CODES:**

- 01 Caucasian (White, European)
- 02 Hispanic
- 03 African American
- 04 American Indian/Alaska Native
- 05 Asian/Pacific Islander
- 06 Mixed Race
- 07 Unknown

# **FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA**

## **Adult Offender Treatment Program**

### **LEVEL 1**

Level 1 focuses on denial, talking about the abuse, being accountable for your offense and looking at the effect abuse has had on others.

- ❖ Education about the process of sexual abuse and preventing future abuse
- ❖ Journaling (as directed)
- ❖ Understanding denial and how it influences behavior
- ❖ Effects of abuse on others / Victim Empathy
- ❖ Dynamics of Abuse
  - Reservoir of motivation
  - Triggers, releasers
  - Thinking errors, cognitive distortions
  - Deviant thoughts
  - Environmental opportunities
  - Attributes of the victim
  - Describing abuse of all victims
- ❖ Presentation of Abuse Dynamics
- ❖ Passes a polygraph revealing all victims
- ❖ Completion of treatment expectations, becoming a healthy person
- ❖ Caught up on all fees

### **LEVEL 2**

Level 2 focuses on victim empathy, skill building and continuing the focus on accountability.

- ❖ Expanding self awareness, Johari window
- ❖ Boundaries
- ❖ Victim Empathy
- ❖ Anger awareness and management
- ❖ Assertiveness
- ❖ Sexual Inventory
- ❖ Sexual history
- ❖ Presenting sexual history
- ❖ Family history and dynamics, genograms
- ❖ Transition to Level 3
- ❖ Caught up on all fees

### **LEVEL 3**

Level 3 This level requires weekly participation and self-disclosure. Individuals who do not participate will remain in the group until they show consistent participation.

- ❖ Able to openly talk about abuse in group and to family
- ❖ Demonstrates a clear understanding of his responsibility for his offenses and is accountable for the consequences
- ❖ Talks about and intervenes when deviant thoughts or fantasies arise and does not minimize the risk of reoffending.
- ❖ Takes full responsibility for offense and does not minimize or blame others for his behavior.
- ❖ Identifies and understands the emotional needs that were met through offending and has learned to meet emotional needs in a healthy way.
- ❖ Has made serious lifestyle changes to minimize risk and does not put self in situations that are risky or could be perceived by others as risky.
- ❖ Has learned how to handle problems appropriately and has adequate social skills to address problems in an open and honest manner.
- ❖ Has developed a sense of self-awareness.
- ❖ Practices anger management, assertiveness skills inside and outside of group. Talks about how he uses them outside of group.
- ❖ Completes updated dynamics of abuse diagram.