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

INDIVIDUAL CLIENT INTAKE FORM

Date	New Client _____ Returning Client _____	Name of Client		
Date of Birth	Age	Gender ____ Male ____Female ____Other	Preferred Pronoun	Occupation/Grade If minor
Street Address	City	State	Zip Code	Employer or School if Minor
Marital Status Single ____ Married _____ Divorced _____ Widowed _____	Race/Ethnicity _____ Caucasian ____ African American ____ Latino/Hispanic _____ Asian/Pacific Islander ____ American Indian/Alaska Native ____ Mutiracial			
CONFIDENTIAL COMMUNICATION: To protect confidentiality please provide a contact phone number.	Phone Number:			

If Client is a Minor:

Parent/Guardian Name			Relationship to Client	Contact Number
Date of Birth	Age	Gender ____ Male ____Female ____Other	Preferred Pronoun	Occupation

Is Client a victim of a crime? (Yes/No)	Date:
Has a Police report been filled? (Yes/No)	Police Event #
Have you applied for victim funding? (Yes/No)	What Type? Date

Household Information

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

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

Main Reason Client is Seeking Services

	Adult: Victim of domestic violence		Child: Victim of sexual abuse		Parent of victim of child sexual abuse
	Adult: Victim of sexual abuse		Child: Victim of physical abuse/neglect		Sibling of victim of sexual abuse
	Adult: Victim of sexual abuse as a child		Child: Victim of domestic violence		Victim of violent crime

Referral Source

Name	Agency	Contact Information

Description of Presenting Problem(s):

If you are the parent or guardian of a child victim of sexual abuse please answer the following:

Who has legal custody of your child/children?
Who has physical custody of your child/children?
Where is child victim receiveng treatment?
Is offender incarcerated? (Yes/No/Unknown)
Is offender in Treatment? (Yes/No/Unknown)

FAMILY AND CHILD TREATMENT OF SOUTHERN NEVADA

INTAKE QUESTIONNAIRE

CLIENT HISTORY

Based on the scale below, please indicate how upsetting the problems have been to the **client:** _____
Mildly upsetting 1 2 3 4 5 6 7 8 9 10 Extremely upsetting

If the client is a minor:
Based on the scale below, please indicate how upsetting the problems have been to the **parent(s) and/or family:** _____
Mildly upsetting 1 2 3 4 5 6 7 8 9 10 Extremely upsetting

Do currently feeling like harming yourself? YES/NO _____ Do you currently feel like harming someone else? Yes/No _____

If you answered yes to either of these questions, please notify therapist.

EDUCATION: What is the last grade or degree you completed?

RELIGION: As a child: _____ As an adult: _____ Do you consider your self active? Yes/No _____

LEGAL HISTORY: Have you ever been arrested? Yes/No _____ If yes, please explain:_____

MEDICAL Current Medical Problems: _____
_____

Prescribed Medications: _____
_____

Please list any of the following symptoms/behaviors that you (the client) or anyone in your family have experienced within the last 6 months:

Overeating; Loss of Appetite; Smoking; Crying; Vomiting; Phobic Avoidance; Temper Outbursts; Insomnia; Laziness; Aggressive Behavior; Loss of Control; Procrastination; Drinking too much; Working too much; Suicidal Thoughts; Suicidal Attempts; Compulsive Behaviors; Difficulty Concentrating; Withdrawing from Others/Isolating Yourself; Difficulty Sleeping; Can't Keep a Job; Taking too Many Risks; Being Impulsive; Feelings of Depression; Excessive Anxiety or Worry; Fatigue/Tiredness; Restlessness; Feeling Easily Irritated; Feeling Helpless; Anger; Feelings of Guilt; Hallucinations (visual or audio); Relationship Problems; Sexual Problems.

Self/Client:

Family Members:

CLIENTS FAMILY OF ORIGIN HISTORY

How would you describe your family? Very close, Somewhat close, Distant, No contact? _____

SIBLINGS

Number of Brothers: _____ Ages: _____ Number of Sisters: _____ Ages: _____

FATHER Biological _____ Adopted _____ Step-father _____

Living? Yes/No _____ If alive, age: _____

Describe your relationship. Is it Excellent, Good, Fair, Poor, or Abusive? _____

MOTHER Biological _____ Adopted _____ Step-mother _____

Living? Yes/No _____ If alive, age: _____

Describe your relationship. Is it Excellent, Good, Fair, Poor, or Abusive? _____

In reference to your parents, who were you closer to as a child?_____ Who were/are you closer to an adult? _____

DOMESTIC VIOLENCE

Are you currently a victim of violence or coercion within your home or relationship? Yes/No _____
Have you in the past been a victim of violence or coercion in your home or relationship? Yes/No _____
Are you currently fearful for your safety? Yes/No _____

If there is any additional information you would like your therapist to know, please write below.

FAMILY AND CHILD TREATMENT

8080 W. Sahara Ave., Suite D. Las Vegas, Nevada 89117
Phone: (702) 258-5855 Fax: (702) 258-9767

CONSENT FOR TREATMENT AND NOTICE OF PRACTICES

By signing this agreement, you are giving your voluntary consent to participate in treatment at Family and Child Treatment of Southern Nevada (FACT) and that you are not aware of any reason why you should not proceed with therapy. As a client of FACT, you understand that this agency does not discriminate or refuse professional service to anyone based on race, gender, religion, natural origin, physical disability or sexual orientation.

The clinical staff is comprised of Psychologists, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Marriage and Family Therapist Interns and Clinical Social Work Interns. Staff is expected to perform their services in accordance with their State Board's ethical standards and practices.

You should expect benefits from your treatment, but understand that individual results may vary. Your desired outcomes cannot be guaranteed. Progress happens at a different pace and level for each individual. If at any time you are unsatisfied with your progress, or the services you are receiving, you should address these concerns with your therapist before terminating treatment.

Termination Policy
By requesting counseling services from FACT you are entering into a treatment contract. Your appointment time has been reserved for you. If you are unable to keep your scheduled appointment time you must call 24 hours in advance. **If you fail to provide 24-hour notice for 2 consecutive sessions or you show a pattern of missing appointments, your case will be closed. Also if you miss or cancel an appointment and do not reschedule within a two-week time frame** (unless an agreement has been made between you and your therapist) **your case will be closed.** If in the future you wish to re-open your case, you may do so but please note that your case will have to be re-assigned to the next available therapist and you may be charged another intake fee.

The therapist/agency has the right to terminate treatment with a client if the therapist believes that a client is not benefiting from treatment or if the issues are beyond the therapist's professional expertise or scope of practice or the agency's mission. Referrals will be given to another resource.

Grievance
I understand that as a client, if I have a complaint, I have a right to due process. The following steps are needed to ensure proper resolution:

1. Schedule an appointment to meet with the therapist to discuss issues. (we will schedule within 10 business days).
2. If unsatisfied you may request, a meeting with the program manager (we will schedule within 10 business days).
3. If further action is requested, you may put your grievance in writing to the Executive Director. They will review the grievance and respond within 15 business days of our receipt of the grievance.

After Hours and Emergency Contact Numbers
For non-emergent after hours calls you may leave a message for your therapist by calling (702) 258-5855, they will return your call on **their** next workday. All emergency and crisis calls should be directed to your local emergency medical service center or by calling 911.

Client Printed Name **Date**	**Print Name and Credentials of FACT Representative** **Date**
Signature of Client or Parent/Guardian **Date**	**Signature of FACT Representative** **Date**

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.

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

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).

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.

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 (EEOP));
2. Juvenile Justice and Delinquency Prevention Act (JJDPA) 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
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**

Signature of Client or Parent/Guardian **Date** **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: _____
Individual Name/Title: _____
Address: _____
Phone: _____ ext._____ Fax: _____
Email: _____

Specific information to be released:

_____ Diagnosis	_____ Presence/Participation in Treatment	_____ Termination Summary
_____ Psychiatric Evaluation	_____ Demographic Information	_____ Current Treatment Update
_____ Psychosocial Assessment	_____ Psychological Evaluation	_____ Progress in Treatment
_____ Treatment Plan/Summary	_____ Current Medications	_____ 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)

___X____ 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

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:

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

PRESENTING ISSUES CODES:

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