ADDMISSIONS & INTAKE ASSESSMENT

SECTION 1

NO LIMITS, LLC

ADMISSION INFORMATION

NO LIMITS, LLC (NLR) requires a complete admission study to assure that all placements meet the needs of and the interest of each applicant and their parents, as well as other legal guardians and/or referring agency representatives. The following information is required for the admission study and/or admission to program.

- □ 1. Complete application form (including ALL requested signatures)
- □ 2. Social History
- □ 3. Psychological evaluation within past year (and other reports available)
- □ 4. Pertinent records of last several placements
- □ 5. History of court involvements
- □ 6. Copy of Birth Certificate
- □ 7. Copy of court order if in custody of DSS or other guardian
- □ 8. Physical examination (within 6 months prior to application)
- □ 9. Social Security card
- □ 10. Current IEP
- □ 11. Medical History/Medical Records/Doctor's Order Forms/Medication Education Information (on prescription drugs)
- □ 12. Medicaid Card (Upon Admission)
- □ 13. High Risk Intervention Orders
- □ 14. Discharge Summaries, if applicable
- □ 15. Progress summaries, if applicable
- □ 16. Educational Summaries/Placements
- □ 20. Diagnosis
- □ 21. Valid treatment plan addressing contractual services and signed by the client and/or/guardian/parent
- □ 22. Valid consent form to exchange information between agency and area authority.
- □ 23. Admission Assessment
- □ 24. Treatment Orders signed and dated prior to service provisions
- □ 25. Service Documentation
- □ 26. Service Notes

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FAX: (336) 217-716 Email: nolimitsresidentialcarellc@gmail.com

No Limits, LLC CLIENT ORIENTATION

By my signature below, I certify that the statements listed below are true.

- ☐ I have been given a copy of the Client Handbook and Program Rules.
- ☐ I have received an explanation of and signed the Client's Rights form.
- ☐ I have received an explanation of the complaint and grievance process.
- ☐ I have received a description of different ways I can provide input into my services and provide feedback.
- ☐ I understand and have been given a copy of Notice of Privacy Practices.
- ☐ I have signed the client HIPAA agreement.
- ☐ I have been given an explanation of the confidentiality policies.
- ☐ I have been given an explanation of and signed the Consent for Treatment.
- ☐ I have been given information about behavioral expectations of clients and am aware that this information is also contained in the Client Handbook.
- ☐ I have been given information about criteria for being admitted to services, and for discharged.
- ☐ I have been informed about staff response if they identify potential risk to my well-being.
- ☐ I understand hours of operation.
- ☐ I have received information about standards of professional conduct.
- ☐ I have been informed about possible reporting and follow-up requirements for clients who are mandated (court-ordered) to services, regardless of discharge status.
- ☐ I have been assigned to my primary worker.
- ☐ I understand and have signed forms with description and explanation of financial obligations, fees, and any financial arrangements for services performed.
- ☐ I understand the health and safety policies regarding: restraint/seclusion, use of tobacco products, legal and illegal drugs, prescriptions medication and weapons brought into the facility.
- ☐ I understand the Program Rules and understand that the program may place restrictions on my customary rights and privileges, possible consequences of attitudes and behaviors, and that there will be ways to regain rights or privileges that have been restricted.
- ☐ I have been given a tour of the facility including: emergency exits, fire suppression equipment, first aid kits, emergency shelters, bathrooms, group therapy rooms.
- ☐ I have been asked if I have an advance directive, and have been offered education about this if I desire.
- ☐ I have been informed about the purpose and process of the screening and assessment.
- ☐ I have been informed about how my Treatment Plan will be developed; how I am expected to participate in the development of the plan and the achievement of my goals; the expected course of my treatment; how motivational incentives may be used; and expectations for legally required appointments, sanctions, or court notifications.
- ☐ I have been informed of the name of the person responsible for coordinating my services.

Assigned Individual Staff:_____

Client Printed Name: _____

Client Signature: _____ **Date:** _____

Consumer Name: Medicaid Number: Record Number:

NO LIMITS, LLC

Residential Treatment Application

Date of Application: _____ **Date of Service Needed:** _____

Type of referral Needed/CFT Recommendation:

☐ Residential Treatment Level 2
☐ Residential Treatment Level 3

Section I: Consumer Information

Consumer's Name: _____ Nickname: _____
Social Security Number: _____ Date of Birth:_____Age:_____ Sex:_____
Medicaid Number**:**_____ County: _____Weight:_ Height:_ Consumer's
Current Address:_____
Consumer's Phone Number: _____Current Living Arrangement :_____
Place of Birth:_____Primary Language: _____
Distinguishing Features (i.e., scars, tattoos, birthmarks, etc.): _____

Section II: Guardian Information

Legal Guardian: _____
Relationship: _____ County of Legal Custody: _____
Guardian's Address: _____
Guardian's Phone Number: _____ Cell:_____
If a Guardian ad Litem has Been Appointed Please List Name and Contact Number:

Section III: Consumer Primary Referral Source Information:

Referring Agency: Support ☐ DJJ ☐ DSS ☐ County: _____
Other: _____
Provider Agency: _____ Phone #: _____
Agency Contact Person: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Emergency Contact: _____ Relationship to Consumer: _____
Contact #: _____ Fax#: _____ Pager/Cell#: _____
Address: _____

Section IV: Clinical/Diagnostic Information:

DSM IV-TR Multi-Axial Diagnosis

Diagnoses:	Effective Date:	Source:
Axis I:_____,_____,_____,_____		
Axis II:		
Axis III:		
Axis IV: _____ _____ _____		
Axis V:		

CALOCUS Score: _____

IQ: _____ Verbal: _____ Performance: _____ Full Scale: _____

Examiner: _____ Date: _____

History of Abuse

☐ Victim of Neglect: _____
☐ Victim of Physical Abuse: _____
☐ Victim of Sexual Abuse: _____
☐ Victim of Emotional Abuse: _____
☐ None

If checked please provide a written description. If DSS involvement please attach documentation.

Medications	Prescribing Physician	Dosage/Frequency	Date Started / Compliant

Section V: Medical Information

Allergies: _____

Special Dietary Needs: _____

Medical Conditions (past and present): *Please note most recent occurrence*

☐ **Lice**	☐ **Bulimia**	☐ **Eczema**
☐ **Anemia**	☐ **Anorexia**	☐ **Asthma**
☐ **Drug/Alcohol Abuse**	☐ **Measles**	☐ **Hay Fever**
☐ **HIV/AIDS**	☐ **Mumps**	☐ **Convulsions**
☐ **Sexually Transmitted Disease**	☐ **Chicken Pox**	☐ **Sinus Problems**
☐ **Ringworm**	☐ **Sickle Cell Anemia**	☐ **Diabetes**
☐ **Tuberculosis**	☐ **Migraine Headaches**	☐ **Hepatitis**
☐ **Chronic Urinary/Bowel Problems**	☐ **Rubella**	☐ **TBI**

Other: _____ Other: _____ Other: _____

Name and Address of Pediatrician: _____

Name and Address of Dentist: _____

Date of Last Phys. Exam: _____ Last Dental Exam: _____ Last Eye Exam: _____

Dental Appliances: ☐ Yes ☐ No Contacts/Glasses: ☐ Yes ☐ No

Medical Insurance Company: ☐ Medicaid _____ ☐ NC Health Choice _____

Private Ins.(Agency): _____

Insurance Policy Number: _____

Insurance is in Whose Name? _____

Any Other Third Party Insurance? _____

Section VI: Strengths/Abilities/Preferences

Strengths/Capabilities: _____

Friendships/Social/Peer Support: _____

Religion/Spirituality: _____

Cultural/Ethnic Concerns: _____

Meaningful Activities (community involvement, volunteer activities, leisure recreation, other interests):

Goals for Independent Living: _____

Section VII: Presenting Problems/Concerns, Reason for Referral (specify)

Section VIII: Previous Treatment Interventions

Outpatient	Date	Effectiveness

Section IX: Placement History

Placement (Begin w/Current Placement)	Dates (From – To)	Reason for Discharge

Section X: Current Emotional/Behavioral Problems

Please describe behavior and date of the last incident.

☐ Abandonment Issues	☐ Anxiety	☐ Arson
☐ Alcohol/Drug Abuse	☐ Antisocial Behavior	☐ Stool/Feces smearing
☐ Assaultive (Physical)	☐ Assaultive (Sexual)	☐ Assaultive (Verbal)
☐ Bedwetting	☐ Eating Disorder	☐ Depression
☐ Property Destroying	☐ Fire Setter	☐ Developmental Disability
☐ Homeless	☐ Hyperactive	☐ Impulsive
☐ Lying	☐ Low Self-Esteem	☐ Loss/Grief Difficulties
☐ Physical Impairment	☐ Mental Retardation	☐ Parent Neglect Issues
☐ Perception of Reality	☐ Phobic Behavior	☐ Physical Disability
☐ Self-Destructive Behavior	☐ Sibling Related Difficulty	☐ Oppositional
☐ Social Immaturity	☐ Sexually Inappropriate Behavior	☐ Stealing
☐ Suicidal	☐ Running Away	☐ Truancy
☐ Unruly/Ungovernable	☐ Cruelty to Animals	☐ Hygiene/Cleanliness Issues
☐ Problems with Sleep	☐ Gang Related Activity	☐ History w/ Weapons

Other: _____

Aggressive or Violent Behavior Alert

Please describe the nature of the acting out behaviors:

☐ Verbally Aggressive, Frequency: _____

Description: _____

_____

_____

☐ Physically Aggressive, Frequency: _____

Description: _____

_____

_____

☐ Property Destruction, Frequency: _____

Description: _____

_____

_____

Has the Behavior Resulted in Injury to Others? ☐ Criminal Charges? Please describe:

_____

_____

_____

_____

Aggression is: ☐ Impulsive ☐ Planned ☐ Instrumental ☐ Triggered by Fearfulness

Where is the Client Aggressive:

_____

_____

Known Triggers, Please Describe:

_____

_____

Main Targets of Aggression: ☐ Peers ☐ Authority Figures ☐ Family Members (Please be specific)

_____

_____

_____

_____

Please Describe the Most Recent Episode of Aggression

_____

_____

_____

_____

_____

_____

History of Self-Injurious/ Risky Behaviors

Self-Injury	**Check all that apply:** ☐ Cuts on Body ☐ Conceals Cutting- Indicated Area ☐ Other Forms of Self-Injury (please describe): _____ Has Self-Injury ever Required Medical Attention? ☐ Yes ☐ No (Please explain): _____
Suicidal Characteristics	**Check all that apply:** ☐ Suicidal Thoughts ☐ Past Suicide Attempts ☐ Suicidal Plans (describe): _____ Methods Used in Previous Attempts (describe): _____ Were Attempts Planned: ☐ Yes ☐ No ☐ Sometimes ☐ Don't know
Homicidal Characteristics	**Check all that apply:** ☐ Homicidal Thoughts ☐ Past Attempts to Harm Others ☐ Homicidal Plans (describe): _____ Methods Used in Previous Attempts (please describe): _____ Were Attempts Planned: ☐ Yes ☐ No ☐ Sometimes ☐ Don't know Does Consumer have Access to Weapons? ☐ Yes ☐ No Please Explain: _____
History of AWOL	Runs Away from Home: ☐ Yes ☐ No Has Run from Previous Placements: ☐ Yes ☐ No In the Past Year how Many Times has Consumer Run? _____ Where Does He/She Go? _____ How Long is Consumer Typically AWOL? _____
Substance Abuse History	**Check all that apply:** ☐ Marijuana Frequency: _____- Last Used: _____ ☐ Cocaine Frequency: _____ -Last Used: _____ ☐ Heroin/Opiates Frequency: _____- Last Used: _____ ☐ Amphetamines Frequency: _____- Last Used: _____ ☐ Inhalants Frequency: _____- Last Used: _____ ☐ Hallucinogens Frequency: _____- Last Used: _____ ☐ Alcohol Frequency: _____- Last Used: _____ ☐ Other: Frequency: _____- Last Used: _____ Explain: _____
Sexual Behaviors	Describe any Sexualized Behaviors Exhibited by Consumer (i.e. peeping, sexual acting out, predatory behaviors, prostitution): _____ _____ _____ _____
Psychotic Behaviors	Please Describe any Past/Present History of Psychosis: _____ _____ _____ _____

Section XI: Family Information

Biological Mother's Name: _____

Address: _____

Telephone Number: Home: _____ Work: _____ Cell: _____

Ethnicity: _____ Education Level: _____ (Unknown ☐)

Criminal Record: ☐Yes ☐No ☐Unknown

Biological Father's Name: _____

Address: _____

Telephone Number: Home: _____ Work: Cell: _____

Ethnicity: _____ Education Level: _____ (Unknown ☐)

Criminal Record: ☐Yes ☐No ☐Unknown

Check all that apply:
Are Parents: ☐ Married ☐Separated ☐ Divorced ☐Never Married ☐Deceased Mother ☐Deceased Father

Have Parental Rights Been Terminated: ☐Yes ☐No

If so, Who and When?

_____

_____

Siblings:

Name	Age	Gender

Are Siblings in Out-of-Home Placements? ☐ Yes ☐ No

If yes, please specify: ☐ DSS Foster Care ☐ Relatives ☐ Incarcerated ☐ Group Home ☐ Other:

Explain: _____

Section XII: Family Social History

Include description of social history, and significant family events leading up to referral, and living arrangement prior to referral. If checked please explain.

☐ Criminal Activity	☐ Child Abuse
☐ Inappropriate Sexual Behavior	☐ Treatment Disruption
☐ Psychiatric Illness	☐ Substance Abuse
☐ Suicide	☐ Other:

If other pertinent family history please document separately and attach.

Section XIII: Authorized Contacts/Resources

Name	Relationship	Address	Telephone Number	Types of Contact (supervised, letter, etc.)	Date of Release of Information

Special Conditions/Restrictions for HomeVisits? _____

Section XIV: School Information

Last School Enrolled: _____ District: _____

Grade: _____ Special Classes: ☐EH ☐LD ☐Resource ☐BEH ☐Homebound ☐Other: _____

Any History of Truancy? ☐ Yes ☐ No Grade(s) Repeated: _____ Current IEP? ☐ Yes ☐ No

Suspensions/Expulsions: _____

Section XV: Agency/Provider Involvement

Indicate all agencies currently involved:

☐ DSS_____ ☐ Mental Health Provider _____ ☐ DJJ_____

☐ Vocational Rehabilitation_____ ☐ Other: _____

Section XVI: Court History

Does Consumer Have a Criminal Record? ☐ Yes ☐ No

Offenses	Conviction Dates	Tried as Juvenile or Adult

Pending Charges: _____

Is Consumer on Probation? ☐ Yes ☐ No Name and Contact: _____

Is Placement Court Ordered? ☐ Yes ☐ No **(If "Yes, attach court order)**

Section XVII: Final Comments

Estimated Length of Stay: ☐ 90 Days ☐ 180 Days ☐ 270 Days ☐ 360 Days

Check All That Apply

Anticipated Discharge Plan: ☐ Return Home ☐ Step Down Placement ☐ Community Supports

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signatures:

Legal Guardian	**Print Name**	**Date**
Social Worker	**Print Name**	**Date**
Case Manager	**Print Name**	**Date**
CC/DJJ	**Print Name**	**Date**
Care Coordinator	**Print Name**	**Date**

CONSENTS SECTION 2

NO LIMITS, LLC

CLIENT: _____ **RECORD NO**: _____

MEDICATION ADMINISTRATION
(CONSENT)

I, the parent or legal responsible person of _____give my consent and authorization for the admission of medication in the IGH program as prescribed by a physician. This includes my permission for the administration of the following non-prescription drugs:

_____ _____
Legally Responsible Person Date

_____ _____
Legally Responsible Person Date

I_____, do hereby recommend that it is medically safe for to receive the following prescribed or non-prescribed medication(s) and I have advised patient of side effects, reactions, effectiveness, etc. of these medications.

_____ _____
Physicians Date

Note: If child is on any prescription medication, education information including warnings, cautions, side effects, what to do if dosage is missed, etc. must be included with this form. Information can be obtained through physician and/or pharmacy.

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NO LIMITS, LLC

CLIENT: _____ **RECORD NO**: _____

Medical Agreement

In the event that I (we) cannot be reached, I hereby give my consent and authorization to the staff of NRC to provided and/or consent to the administration of any drugs and medical, dental, or surgical treatment which, in the opinion of the physician selected by NRC is deemed necessary for the well being of my child. I further agree to be responsible for any cost that is incurred in securing these services. If necessary, I will furnish directly to a physician or hospital documented financial information utilized for computation of fees.

I give permission to take my child to _____ or other medical facilities selected by NRC for emergency medical attention.

_____ _____
Legal Responsible Person **Date**

_____ _____
Legal Responsible Person **Date**

_____ _____
Witness/Title **Date**

Medical Insurance Information

Name of Participant: _____

Name of Policy Holder: _____

Address: _____

_____

Phone #: _____

Insurance Co.: _____

Address: _____

Phone #: _____

Policy #: _____

If the participant is covered by Medicaid, please note the number _____ and the County of Issuance _____. If participant is not covered by either family insurance or Medicaid, who will pay for any medical/dental expenses? _____

Provider: _____

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NO LIMITS, LLC

CONSENT FOR TREATMENT

Client Name: _____

Date of Birth: _____

Social Security No.: _____

Record No.: _____

I have received the Resident Handbook for NO LIMITS,LLCand understand the terms and conditions explained therein.

I_____(specify relationship to client) consent for this resident to be admitted to this program. In doing so, I also agree that this resident will abide by the terms stated in the Resident Handbook.

I agree to allow NO LIMITS,LLCstaff to implement regular and accepted therapeutic interventions in meeting the treatment goals and plans mutually agreed upon by the members of the treatment team.

I have received a full explanation regarding the use of restrictive interventions (physical and otherwise) by staff of this agency. This procedure may be used if the resident's behavior warrants such an intervention. I understand that restrictive intervention is defined as an intervention procedure which presents a significant risk of mental or physical restraint, excluding protective devices, or isolation time-out; or any combination thereof. The goal of restrictive intervention shall be to prevent the resident from doing harm to themselves, other residents, staff or property. Restrictive intervention is not a punishment, therefore no excessive force or mechanical device shall be used to restrain this resident. Restraints will only be utilized as last resort NLR will make all attempts to use the least restrictive intervention,

_____By initialing this section of the consent, I am indicating a preference to be noticed when restrictive restraint (physical or otherwise) is used on this resident. Failure to initial this section indicates my preference not be notified.

_____By initialing this section, I am indicating a preference that another source other than myself should be notified when restrictive restraint is used on this resident. NOTE: Indicate the name of contact phone(s) of the person who should be notified._____

I grant permission for this resident to participate in all NO LIMITS,LLCouting and independent living programs. I am aware that some of these outings will involve the resident being transported away from the facility. It is my understanding that NO LIMITS,LLC will inform me in advance if the outing requires overnight stay or travel out of state. Based on this understanding, I agree not to hold NO LIMITS,LLC legally or financially liable in the event that an accident or injury occurs to this resident.

I authorize NO LIMITS,LLCt o transport this resident to and from medical, dental, mental health and related appointments, home visits, etc. if the need arises. I understand that I will be notified of any serious medical or related illness affecting the resident.

I understand that I will be notified if a change in the resident's treatment regime and medications. I understand that prescription medications will be administered to this resident only if ordered by a licensed physician whose care for the resident has been recognized by the resident's parent or legal guardian.

I agree to provide NO LIMITS,LLCany and all medications prescribed for this resident. In addition, I agree to provide this agency with a written prescription from a physician for each medication that I supply this agency for the resident.

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NO LIMITS, LLC

I agree that during tours of this facility by professional and related organizations, they may be allowed to have brief discussions with this resident, and with the understanding that NO LIMITS,LLC will take all measures to ensure the resident's confidentiality.

I agree to allow this resident to be photographed, audiotaped, or videotaped for training purposes strictly for NO LIMITS, LLC staff. These items may be used for security purposes in the event of a runaway or accident to serve as a means of identification.

I grant NO LIMITS, LLC permission to obtain emergency care for this resident, if needed, until at such time that I can be contacted to authorize further care.

I authorize NO LIMITS, LLC to provide educational assistance to this resident, including issues such as human sexuality, abstinence, contraception, drug and alcohol abuse, sexually transmitted disease prevention, housing issues and other discussions relevant to obtaining basic life skills leading to independent and interdependent living.

I have been provided the NO LIMITS, LLC Resident Rights Brochure, and Client Grievance Procedure. I understand that the resident or his/her guardian may use the grievance procedure to notify the agency or other public agencies to file a grievance in the event they disagree with services rendered or decisions reached by the agency regarding the resident's care.

I would like the following exceptions or additions made to this consent:

_____

NOTE: I agree that this consent and document referred to herein may be amended on an as needed basis, and information required while in the performance of treatment may be released without client's consent. This agreement will expire one year after the date it is signed. When this agreement expires, a new admission agreement will be provided.

Signatures:

_____ _____
Legally Responsible Person Date

_____ _____
Witness Date

_____ _____
NO LIMITS, LLC Staff/Title Date

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NO LIMITS, LLC

CONSENT FOR RELEASE OF CLIENT INFORMATION

CLIENT: _____ **RECORD NO**: _____

I, the above named, hereby authorize _____
[Name of Center/Program to Release Information]

to release specified information to _____
[Name of Person/Agency to Receive Information]

and in addition authorize _____ to release
[Name of Center/Program to Release Information]

specific information to _____.
[Name of Person/Agency to Receive Information]

This information shall include only that of the nature and to the extent which is specified below:

[ ] Reason for Referral;

[ ] Psychiatric, Psychological, Social, Medical Information Affection CURRENT Functioning

[ ] CURRENT Medications;

[ ] History of Psychotropic Drugs Prescribed;

[ ] School Academic Achievement and Behavior,

[ ] _____

This information will be used for SUPPORT OF THE NEED FOR SERVICES, TO FACILITATE AND COORDINATE DELIVERY OF SERVICES IN BEST INTEREST OF CLIENT.

Other Information: _____

I understand the contents to be released, the need for the information, and that there are state and federal regulations protecting the confidentiality of authorized information, and cannot be released without my written consent unless otherwise provided for in the regulations. I herby acknowledge that this consent is truly voluntary and is valid for a period not to exceed one year. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken. Any revocation of consent must be in writing. This data shall include only that of the nature and to the extent which is specified above. NOTE: The records release may include psychiatric, drug abuse, alcohol abuse, HIV and/or AIDS information (if applicable).

_____ OR _____
Client Signature Parent/Guardian/Legally Responsible Party

_____ _____
Witness Signature Date

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FAX: (336) 217-716 Email: nolimitsresidentialcarellc@gmail.com

NO LIMITS LLC.

I,_____consumer, parent/guardian give my consent for No limits, LLC, Inc. to provide mental health service for the above-named individual. I reserve the right revoke the consent for any of the below listed releases at any time while in service. In addition, I reserve the right to refuse, at any time, any services been offered to me. I understand that consent is valid for no more than (1) year from the signature date unless revoked by me by a written notice.

GENERAL CONSENT TO TREATMENT

I acknowledge that information has been provided to me regarding the alleged benefits, risks and possible alternative methods of receiving treatment services from No limits, LLC. A representative of No limits, LLC, Inc. has explained the anticipated process and course of treatment to me. At any time, this consent may be revoked with prior written notice.

ACKNOWLEDGEMENT OF PROVIDER CHOICE

I acknowledge that I have been educated about the choices of provider agencies that offer the services I am eligible for, and I have freely chosen HealthCore Resource, Inc. without duress or coercion. I also understand that I may change service providers at any time, if possible, reasonable notice is needed so that an No limits, LLC, Inc. may arrange the transition of services to the new provider that I have chosen. At any time, this consent may be revoked with prior written notice.

PERMISSION TO SEEK EMERGENCY MEDICAL CARE

I hereby give my permission for No limits, LLC, Inc. to seek emergency medical care, if necessary, from the nearest Hospital or Physician. In case of an extreme emergency, after every attempt is made to reach the responsible party, and a conscious decision is needed, I give the attending physician permission to provide sufficient care that is needed until I can make the decision myself. At any time, this consent may be revoked with prior written notice.

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize No limits, LLC, Inc. to release/exchange information about any emergency care I need to receive, with the individuals listed on the front of this card, identified as my Emergency Contacts. I also authorize No limits, LLC, Inc. to release/exchange infonnation with Value Options, Managed Care Organizations, IMS/On-Target, Local Management Entities, Division ofVR and insurance companies necessary to authorize and process service authorizations and payment claims. I understand my consent is ongoing until revoked by written notice.

CONSENT TO TRANSPORT

In order for a member of the No limits, LLC, Inc. staff to utilize either their own vehicle or yours in connection with their assignment to your services, please be advised that No limits, LLC does not have insurance to cover use of staff owned vehicles or staff use of consumer owned vehicles. With full understanding of this and with awareness of the hazards inherent in automotive transportation, I hereby voluntarily give consent for transportation by staff of No limits, LLC, further give consent for any vehicle that it provides, and I hereby release and discharge No limits, LLC, Inc. from all claims, demands, 'damages, actions, and from any and all liability of any nature whatsoever for any loss, property damage, bodily injury, harm or complication of any kind that I may sustain as a direct or indirect result of my using any transportation services provided by No limits, LLC, Inc.. At any time this consent may be revoked with prior written notice.

24 EMERGENCY RESPONSE VIA CRISIS LINE

No limits, LLC, Inc. maintains emergency or crisis line 24 hours, 7 days a week & 365 days a year and the crisis number of 336-504-8680 has been provided to me. I have also been provided with information on 'how to access the emergency response to the on-call clinician by dialing 336-391-3634 I have been asked to post this number where it is easily accessible in my home.

ACKNOWLEDGEMENT OF ORIENTATION TO SERVICES.

I have received a Professional Disclosure statement and have been oriented to the services I will receive, and have had the opportunity to ask questions. I have received information about my Rights and Responsibilities, Notice of Privacy Practice and I understand that I have a right to be free from harm, abuse, neglect and exploitation and have received the "Client Orientation to Services" handbook. I agree with and will abide by its contents.

I certify the above information is current and has been explained to me so that I may understand it. I certify I had the opportunity to ask questions, and they have been answered. I further acknowledge receipt of the above information in writing, upon my admission and I agree with and will abide by its contents.

_____/_____

CLIENT DATE

_____/_____

LEGAL GUARDIAN NAME (If client is a minor) DATE

Article 4.
Consent to Health Care for Minor.

§ 32A-28. Purpose.

(a) The General Assembly recognizes as a matter of public policy the fundamental right of a parent to delegate decisions relating to health care for the parent's minor child where the parent is unavailable for a period of time by reason of travel or otherwise.

(b) The purpose of this Article is to establish a nonexclusive method for a parent to authorize in the parent's absence consent to health care for the parent's minor child. This Article is not intended to be in derogation of the common law or of Article 1A of Chapter 90 of the General Statutes. (1993, c. 150, s. 1.)

§ 32A-29. Definitions.

As used in this Article, unless the context clearly requires otherwise, the term:

(1) "Agent" means the person authorized pursuant to this Article to consent to and authorize health care for a minor child.

(2) "Authorization to consent to health care for minor" means a written instrument, signed by the custodial parent and acknowledged before a notary public, pursuant to which the custodial parent authorizes an agent to authorize and consent to health care for the minor child of the custodial parent, and which substantially meets the requirements of this Article.

(3) "Custodial parent" means a parent having sole or joint legal custody of that parent's minor child.

(4) "Health care" means any care, treatment, service or procedure to maintain, diagnose, treat, or provide for a minor child's physical or mental or personal care and comfort, including life sustaining procedures and dental care.

(5) "Life sustaining procedures" are those forms of care or treatment which only serve to artificially prolong life and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and other forms of treatment which sustain, restore, or supplant vital bodily functions, but do not include care necessary to provide comfort or to alleviate pain.

(6) "Minor or minor child" means an individual who has not attained the age of 18 years and who has not been emancipated. (1993, c. 150.)

§ 32A-30. Who may make an authorization to consent to health care for minor.

Any custodial parent having understanding and capacity to make and communicate health care decisions who is 18 years of age or older or who is emancipated may make an authorization to consent to health care for the parent's minor child. (1993, c. 150, s. 1.)

§ 32A-31. Extent and limitations of authority.

(a) A custodial parent of a minor child, pursuant to an authorization to consent to health care for minor, may grant an agent full power and authority to consent to and authorize health care for the minor child to the same extent that a custodial parent could give such consent and authorization.

(b) An authorization to consent to health care for minor may contain, and the authority of the agent designated shall be subject to, any specific limitations or restrictions as the custodial parent deems appropriate.

(c) A custodial parent may not, pursuant to an authorization to consent to health care for minor, authorize an agent to consent to the withholding or withdrawal of life sustaining procedures. (1993, c. 150, s. 1.)

§ 32A-32. Duration of authorization; revocation.

(a) An authorization to consent to health care for minor shall be automatically revoked as follows:

(1) If the authorization to consent to health care for minor specifies a date after which it shall not be effective, then the authorization shall be automatically revoked upon such date.

(2) An authorization to consent to health care for minor shall be revoked upon the minor child's attainment of the age of 18 years or upon the minor child's emancipation.

(3) An authorization to consent to health care for minor executed by a custodial parent shall be revoked upon the termination of such custodial parent's rights to custody of the minor child.

(b) An authorization to consent to health care for minor may be revoked at any time by the custodial parent making such authorization. The custodial parent may exercise such right of revocation by executing and acknowledging an instrument of revocation, by executing and acknowledging a subsequent authorization to consent to health care for the minor, or in any other manner in which the custodial parent is able to communicate the parent's intent to revoke. Such revocation shall become effective only upon communication by the custodial parent to the agent named in the revoked authorization.

(c) In the event of a disagreement regarding the health care for a minor child between two or more agents authorized pursuant to this Article to consent to and authorize health care for a minor, or between any such agent and a parent of the minor, whether or not the parent is a custodial parent, then any authorization to consent to health care for minor designating any person as an agent shall be revoked during the period of such disagreement, and the provisions of health care for the minor during such period shall be governed by the common law, the provisions of Article 1A of Chapter 90, and other provisions of law, as if no authorization to consent to health care for minor had been executed.

(d) An authorization to consent to health care for minor shall not be affected by the subsequent incapacity or mental incompetence of the custodial parent making such authorization. (1993, c. 150, s. 1.)

§ 32A-33. Reliance on authorization to consent to health care for minor.

(a) Any physician, dentist, or other health care provider involved in the health care of a minor child may rely upon the authority of the agent named in a signed and acknowledged authorization to consent to health care for minor in the absence of actual knowledge that the authorization has been revoked or is otherwise invalid.

(b) Any consent to health care for a minor child given by an agent pursuant to an authorization to consent to health care for minor shall have the same effect as if the custodial parent making the authorization were present and acting on behalf of the parent's minor child. Any physician, dentist, or other health care provider relying in good faith on the authority of an agent shall be protected to the full extent of the power conferred upon the agent, and no person so relying on the authority of the agent shall be liable, by reason of reliance, for actions taken pursuant to a consent of the agent. (1993, c. 150, s. 1.)

§ 32A-34. Statutory form authorization to consent to health care for minor.

The use of the following form in the creation of any authorization to consent to health care for minor is lawful and, when used, it shall meet the requirements and be construed in accordance with the provisions of this Article.

I, _____, of _____ County, _____, am the custodial parent having legal custody of_____, a minor child, age_____, born_____, ____ . I authorize_____, an adult in whose care the minor child has been entrusted, and who resides at_____, to do any acts which may be necessary or proper to provide for the health care of the minor child, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

[Optional: This consent shall be effective from the date of execution to and including_____,____].

By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the agent named herein.

(SEAL)
Custodial Parent Date

STATE OF NORTH CAROLINA

COUNTY OF

On this _____ day of_____, ____, personally appeared before me the named_____, to me known and known to me to be the person described in and who executed the foregoing instrument and he (or she) acknowledges that he (or she) executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

Notary Public

My Commission Expires:

(OFFICIAL SEAL). (1993, c. 150, s. 1; 1999-456, s. 59.)

§ 32A-35. Reserved for future codification purposes.

§ 32A-36. Reserved for future codification purposes.

§ 32A-37. Reserved for future codification purposes.

§ 32A-38. Reserved for future codification purposes.

§ 32A-39. Reserved for future codification purposes.

NO LIMITS, LLC

Please Note this any information will be verified any false information will result in denial of placement!

Room & Board

Does your child receive any funds are it relates to SSI/SSA or any other types of Disability payments Adoption Assistance received from Social Security Administration ? Yes or No
Note: If you do not receive Social Security you will need to apply and provide this agency with copy of the application. If you have already applied and benefit decision is pending or denied you will need to obtain a letter from Social Security regarding the outcome provide a copy to the letter to Inspirationz Group Home
____Parent Pay: Room and Board is $634.00 for level II & $1340.00 Level III

Social Security Administration Monthly Amount: $_____Date Received:_____

Child Support/Adoption Assistance: Amount $_____Date Received:_____

Due to Inability to pay Room & Board monthly Rate of $_____.00 will be discounted/waived at the Agency Discrepancy.

Client Name:

_____

Address:

_____

City _____State _____Zip _____

Age: _____ Date of Birth: _____

Client SSN:_____Guardian Name and Social:_____

Home Telephone Contact: _____

Cell Telephone Contact: _____

Guardian signature required has authorization to release monthly SSA/SSI or Adoption Assistance and or Disability funds to cover any/all Room and Board fees only, all other fees to be paid by guardian. Guardian understands that the room and board rate changes depending on Level of care and will be responsible for that rate for the specific level of care if it should change agency may or may not waive portions of the fees. Parent Guardian understands the payments are due on the 5th of every month. Parent further understands that it is the policy of NLR that failure to pay the room and board rate will result in a 10 day notice for immediate discharge and understands that NLR will pursue legal action for all funds owed . If there is no income benefits the parent / guardian will be required to pay minimum of $500.00 per month room & board

Guardian Name (Print): _____Date:_____

Guardian Signature: _____Date: _____

Signature:_____Date: _____
Group Home Staff Name/Title:

ASSESSMENTS SECTION 3

NLR Intake Assessment Child/Adolescent

Instructions: To assist us in helping your child, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits.

Information supplied by: Relationship _____

Child's Name: _____

_____

_____

How long has this problem persisted?

_____

_____

Desired outcome or expectations of treatment (changes you would like to make, how we can help)? _____

Has the child been involved in previous counseling?_____Yes_____No

If Yes, please describe: _____

Strengths/Concerns

~~Briefly describe the child's greatest strengths:~~ Extremely .

_____

~~Briefly describe the child's likes and dislikes (including hobbies and interests):~~

Briefly describe the child's main difficulties at home:

_____

Briefly describe the child's difficulties with peers: _____

_____

_____

Briefly describe the child's friendships: .

_____

Medical

Physician's Name: _____

Most Recent Physical Exam: _____Results:_____

Height:_____Weight: _____

Are your child's immunizations up to date? _Yes_____

Most Recent Dental Exam: _____

Any known allergies:_____

List any past or present illnesses, operations, or conditions: _____

List any present physical concerns (e.g., dizziness, headaches, stomach aches, etc.):_____

_____

_____

On average how many hours of sleep does the child receive daily? _____

Does the child have trouble falling asleep at night?_____Yes_____No

If Yes, how long has this been a problem? _____ Describe the child's appetite (during the past week):_____poor appetite_____average appetite_____large appetite

Have there been any recent changes in appetite or sleep? If Yes, please describe: _____

_____

Developmental History

Information unknown due to:_____

Information regarding pregnancy and delivery:

Was the pregnancy planned? Yes _____No _____UnknownWas prenatal care received? Yes _____No _____UnknownDid the pregnancy go full term? Yes _____No _____UnknownWas delivery by cesarean section? Yes _No___Unknown_____

Were there complications with pregnancy or delivery? If Yes, please describe: _____

Guardian states consumer mother used drugs but he had no issues at birth

Substances used by mother or father at time of conception, or by mother during pregnancy (check all that apply)

Father: _____Alcohol _____Marijuana _Cocaine/crack _Other _None _____Unknown Mother:

Alcohol _Marijuana _Cocaine/crack _Other _None _____Unknown Please fill in when the following developmental milestones took place:

Behavior	Age began	Unknown	Comments
Walking	_____	_____	_____
Talking	_____	_____	Toilet trained _____

Please rate your opinion of the child's current development (compared to others the same age) in the following areas. For any identified as below average, please describe:

	Above Average	About Average	Below Average	Describe
Social	_	_	_	_____
Physical	___	___	___	Language
	_____	_____	_____	Intellectual
	_____	_____	_____	Emotional
	____	____	_____	

Education

School attending:_____ Year in school: _____

Is the child receiving special education services?_____Yes_____No

If Yes, circle category, if known: ASD CI ECDD EI HI PI OHI SXI SLD SLI TBI VI DB

How does your child typically perform academically? _____

Has this changed lately?_____Yes_____No If Yes, how? _____

Does better monitored in structured environment with limited freedom in the educational setting

Briefly describe any school difficulties: _____

Current Family Information

What is the family structure? Check all that apply:

_____Single parent mother _____Single parent father _____Parents unmarried

_____Parents married, together _____Parents divorced _____Parents separated

_____With mother and stepfather _____With father and stepmother _____Grandparents

_Child adopted Other, describe_____

Mother's age:_____If deceased, how old was the child when she passed away? _____

Father's age:_____If deceased, how old was the child when he passed away? _____

If parents are separated or divorced, how old was the child then? _____

Number of brother(s)_Their ages ____ _____ ____ ____ ____ _____

Number of sister(s) _Their ages _ _____ _ _ _ _

Child number_____in a family of_____children.

Briefly describe the child's relationship with brothers and/or sisters:

Biological siblings: _____

Step and/or half siblings: _____

Other:N/A_____

If child is being raised by a caregiver other than biological parent, please describe the situation:

Parents' occupations: Mother unknown_____Father Prison_____

Who provides care for child when the caregiver is absent? _____

Briefly describe the type of parenting used in the household: _____

How, and for what reason, is the child disciplined? Our of Home placement / DJJ Involvement

Trauma History

Is there a history or recent occurrence(s) of child abuse to this child?_____YES_____No

If Yes, which type(s):_____Verbal _____Physical _____Sexual _____Emotional _____Neglect

Please describe: _____

Has there ever been a time when you wondered about abuse occurring?_____Yes_____No

If Yes, please describe:_____

Has there ever been a time when Child Protective Services has been involved in the life of this child or its family?

_X___Yes_____No If Yes, please describe: _____

Have there been any other traumas experienced by this child? If Yes, please describe the situation. (ex. scary medical procedures, prenatal stressors, prenatal exposure to substances, accidents, grief and loss, witnessing, experiencing or exposure to violence, natural disasters, any life threatening situation):_____

Religion

How important to your child are spiritual matters? Somewhat Very Much

Is your child and/or family affiliated with a spiritual or religious group? Yes No

If Yes, please describe: _____

Would you and/or your child like your spiritual/religious beliefs incorporated into counseling sessions? Yes No

If Yes, please describe: _____

Cultural/Ethnicity

To which cultural and/or ethnic group do you and/or child belong? _____

Are you and/or your child experiencing any problems due to cultural or ethnic issues? Yes No

If Yes, please describe: _____

Would you and/or your child like cultural/ethnic practices incorporated into your counseling sessions? Yes No

If Yes, please describe: _____

Substance Use History

Personal and Family substance use, past and present

	Client Information						Family Information
	Method of use and amount N/A NO Concerns in the last year of use of any drugs or alcohol	Frequency of use	Age of first use	Age of last use	Used in last 48 hours Yes/No	Used in last 30 days Yes/No	Use in immediate or extended family? Yes*/No
Alcohol							
Marijuana							
Caffeine							
Nicotine							
Other drugs							

*If Yes, Please describe immediate and extended family substance use: _____

_____ _____

Staff Signature

/