A Mother's Love
1227 Westmoreland Drive
Burlington, NC 27217

ADMISSION INFORMATION

Documents Provided By AML, Inc.

- Admission Application
- Application - Voluntary Admission
- Authorization – Medical Care
- Consent for Placement
- Consent for Release of Information
- Client's Medical History Questionnaire
- Central Client Database
- Client Emergency Information
- Crisis Plan
- Dress Code/Laundry
- Informed Consent
- Policy Client Rights
- Screening
- Medication Order Form
- Client Emergency Information Form
- Elopement Policy
- Consent for School Placement Forms

Documents Provided by Area Mental Health/DSS etc.

- Face Sheet
- Service Order
- Doctor's Order for Medication
- Certs (Alamance County)
- Medical Exam (Physical)
- Most Recent Treatment Plan
- Medicaid Card
- Most Recent Psych Evaluation
- Discharge Summary (from previous placement)
- IEP
- Birth Certificate Copy
- Social Security Card Copy
- School Records
- Immunization Record
- Prescription (with at least two weeks of medication remaining)
- Guardianship Form/ Non-Secure Custody

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MCO NAME:
MCO ADDRESS:

PROVIDER: A Mother's Love
ADDRESS: 1227 Westmoreland Drive
Burlington, NC 27217

CLIENT IDENTIFICATION FACE SHEET (Print or Type)

Full Name: (Last, first, middle)		Record Number	Facility Code	Date Admitted
Maiden Name:		Program	County of Residence	Gender
Address:		Race	Ethnicity	Marital Status
		Date of Birth & Age	Educational Level	Citizenship
Home Phone:	Work Phone:	Employment Status	Competency Status	Living Arrangement
Social Security Number: (optional)		Veteran Status	Primary Language	English Proficiency
Guardian/Legally Responsible Person and Address:		EAP Employer Code	Unique Identifier	Referring Source
		Accommodation for Handicapped Needed: (optional)		
Emergency Contact Person and Telephone:		**INSURANCE INFORMATION**		
Family Physician: (name & address)		Health Plan Name: _____ Effective Date: _____ Group #: _____ Insurance Card Number: _____ Name of Insurance Holder: _____		

Monthly Income: _____ Gross Annual Income: (Family) _____

Source of Income: ☐ Food Stamps ☐ Welfare ☐ Retirement ☐ Savings ☐ Unemployment

☐ Self-employment ☐ SSDI ☐ SSI ☐ Wages/Salary ☐ None

Past Mental Health History: ☐ State mental health hospital ☐ This agency ☐ Private practitioner

☐ Private hospital ☐ V.A. ☐ None

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Outpatient prior mental health: ☐ CPS ☐ Private mental health professionals ☐ Community mental health center ☐ Mental retardation facility ☐ PFC ☐ Alcohol center ☐ None

Number of months (outpatient prior): _____

Medication allergies: _____

_____ _____ _____
Client, Parent / Guardian Signature | Witness Signature | Date

Client Name: _____ **Record #:** _____

DIAGNOSTIC DATA

START DATE	ICD 10 CM	P OR R	CODE	DESCRIPTION
	☐ F Code ☐ ☐	☐ Principal		
	☐ F Code ☐ ☐	☐ Primary		
	☐ F Code ☐ ☐	☐ Primary		
	☐ F Code ☐ ☐	☐ Primary		
	☐ F Code	☐ Primary		
	☐ F Code	☐ Primary		
	Pregnancy Status	☐ Yes ☐ No		

SA TREATMENT HISTORY MOVEMENT

START DATE	DRUG CODE	AGE 1st USE	FREQUENCY	ROUTE	CLASS	END DATE

_____ _____
Signature / Title of Person Completing Form **Date**

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Discharge *(when all Area & Contract services cease):*		
Date Final Interview:		Discharge Referral: _____
Date Discharged:		Living Arrangement:_____ ___
Discharge Reason:		_____

_____
Signature / Title of Person Completing Discharge

_____
Date

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APPLICATION FOR VOLUNTARY ADMISSION OF A MINOR FOR TREATMENT IN A MOTHER'S LOVE TREATMENT PROGRAM
(According to NCGS 122C221 Voluntary Admission)

Date: _____ Time:_____a.m./p.m.

I, _____, as parent/guardian/legal custodian for _____ knowing that he/she is mentally ill or a substance abuser and in need of treatment, do hereby voluntarily consent to such treatment by the responsible professional assigned to the care of *A Mother's Love*, and also by its assistants, or designees as is necessary in the judgment of the responsible professional. I understand care and treatment to include routine diagnostic procedures: medical treatment, emergency and crisis intervention, residential care in _____, day treatment and education, psychotherapy, case management, and other therapeutic interventions as required and as provided within *A Mother's Love* continuum.

I am aware that the practice of medicine and residential care is not an exact science and I acknowledge that no guarantees have been made to me as to the result of the treatment or care provided by *A Mother's Love.*

I understand that NCGS 122C-224 requires that a judicial hearing to held within fifteen (15) days after the minor's admission to determine whether the minor meets the legal standards for admission to a residential facility and, if so, to determine the maximum length of treatment at that facility.

I understand that, after admission, the court or the treatment facility may release the minor at anytime when either determines that the minor does not need further treatment, care supervision, guidance, and control (NCGS 122C-224.7 a).

I understand that I may file a written request for discharge an any time; the facility must respond within seventy-two (72) hours, and the facility will either release the minor (NCGS 122C-224.7 b) or will file a petition for involuntary treatment (NCGS 122C-2261).

I understand that if the minor appears to be dangerous to him/her-self or others, the staff will exercise the necessary physical restraints/therapeutic holds (timeout in room and/or medication by doctor's orders only) in order to protect him/her-self and/or others.

This form has been fully explained to me and certified that I understand its contents.

REDISCLOSURE: I understand that, once information is disclosed pursuant to this signed authorization, it is possible that it may no longer be protected by the federal health privacy law (45 CFR Part 164) may not apply to the recipient of the information and therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When AML discloses mental health and developmental disabilities information protected by state law (GS 122C) or substance abuse treatment information protected by federal law (42CFR Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws.

* This authorization expires automatically in one year. The authorization may be revoked by the legal guardian at their discretion by completing the Revocation and Expiration Form found at the end of the admission package.

_____ _____
Parent/Legal Guardian/Custodian Signature Date

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PHYSICAL EXAMINATION INFORMATION
(To be completed by physician)

Height:	Weight:	Blood Pressure	Pulse:
Vision Rt: 20/	Vision Lt 20/	Vision Both 20/	Other:
ORGAN/SYSTEM	**NORMAL**	**ABNORMAL (explain)**	
Pulse			
Hernia (males)			
Eyes/Pupils			
ENT			
Heart			
Lungs			
Abdomen			
Genitalia (males)			
Musculoskeletal			
Neurological			
Neck/Back			
Shoulder			
Elbow			
Ankle/Foot			
Hip			
Knee			
Wrist/Hand			
Skin			
Laboratory			

Additional comments:_____

Doctor's Certification: I, the undersigned physician, certify that I have examined the client, _____.
Physician's name: (print clearly)_____

Physician's signature _____
Street Address_____
City:_____ State:_____ Zip:_____
Date: _____ Phone: _____

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AUTHORIZATION FOR ROUTINE MEDICAL CARE and GENERAL PARTICIPATION

Consumer's Name_____ Consumer #_____
Effective Date:_____

I hereby give permission to *A Mother's Love*, to obtain and provide routine care and treatment necessary for the health and safety of the above named resident and necessary for participation in an active treatment program.

REDISCLOSURE: I understand that, once information is disclosed pursuant to this signed authorization, it is possible that it may no longer be protected by the federal health privacy law (45 CFR Part 164) may not apply to the recipient of the information and therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When AML discloses mental health and developmental disabilities information protected by state law (GS 122C) or substance abuse treatment information protected by federal law (42CFR Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws.

* This authorization expires automatically in one year. The authorization may be revoked by the legal guardian at their discretion by completing the Revocation and Expiration Form found at the end of the admission package.

_____ _____
Signature of Parent/Guardian/Consumer Date

_____ _____
Signature of Witness, Position Date

_____ _____
Signature of QMHP/Designee Date

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I hereby give permission to *A Mother's Love* and its authorized representatives to secure needed emergency medical treatment and authorize the administration of anesthesia and/or the performance of any type of essential emergency surgery in a licensed facility on behalf of the above named resident.

REDISCLOSURE: I understand that, once information is disclosed pursuant to this signed authorization, it is possible that it may no longer be protected by the federal health privacy law (45 CFR Part 164) may not apply to the recipient of the information and therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When AML discloses mental health and developmental disabilities information protected by state law (GS 122C) or substance abuse treatment information protected by federal law (42CFR Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws.

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_____ _____
Signature of Parent/Guardian/Consumer Date

_____ _____
Signature of Witness, Position Date

_____ _____
Signature of QMHP/Designee Date

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AUTHORIZATION FOR ROUTINE MEDICAL CARE and GENERAL PARTICIPATION

Consumer's Name_____ Consumer #_____
Effective Date:_____

I hereby give permission to *A Mother's Love* to obtain and provide routine care and treatment necessary for the health and safety of the above named resident and necessary for participation in an active treatment program. Services will be provided by the following individuals/facilities:

Individual/Facility:_____

Address:_____

Phone:_____

Individual/Facility:_____

Address:_____

Phone:_____

Individual/Facility:_____

Address:_____

Phone:_____

REDISCLOSURE: I understand that, once information is disclosed pursuant to this signed authorization, it is possible that it may no longer be protected by the federal health privacy law (45 CFR Part 164) may not apply to the recipient of the information and therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When AML discloses mental health and developmental disabilities information protected by state law (GS 122C) or substance abuse treatment information protected by federal law (42CFR Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws.

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_____ _____
Signature of Parent/Guardian/Consumer Date

_____ _____
Signature of Witness, Position Date

_____ _____
Signature of QMHP/Designee Date

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AUTHORIZATION FOR ROUTINE DENTAL CARE and GENERAL PARTICIPATION

Consumer's Name_____ Consumer #_____
Effective Date:_____

I hereby give permission to *A Mother's Love.,* to obtain and provide routine care and treatment necessary for the health and safety of the above named resident and necessary for participation in an active treatment program. Services will be provided by the following individuals/facilities:

Individual/Facility:_____

Address:_____

Phone:_____

Individual/Facility:_____

Address:_____

Phone:_____

Individual/Facility:_____

Address:_____

Phone:_____

REDISCLOSURE: I understand that, once information is disclosed pursuant to this signed authorization, it is possible that it may no longer be protected by the federal health privacy law (45 CFR Part 164) may not apply to the recipient of the information and therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When AML discloses mental health and developmental disabilities information protected by state law (GS 122C) or substance abuse treatment information protected by federal law (42CFR Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws.

* This authorization expires automatically in one year. The authorization may be revoked by the legal guardian at their discretion by completing the Revocation and Expiration Form found at the end of the admission package.

_____ _____
Signature of Parent/Guardian/Consumer Date

_____ _____
Signature of Witness, Position Date

_____ _____
Signature of QMHP/Designee Date

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AUTHORIZATION FOR ROUTINE PSYCHIATRIC CARE and GENERAL PARTICIPATION

Consumer's Name_____ Consumer #_____
Effective Date:_____

I hereby give permission to *A Mother's Love*, to obtain and provide routine care and treatment necessary for the health and safety of the above named resident and necessary for participation in an active treatment program. Services will be provided by the following individuals/facilities:

Individual/Facility:_____

Address:_____

Phone:_____

Individual/Facility:_____

Address:_____

Phone:_____

Individual/Facility:_____

Address:_____

Phone:_____

REDISCLOSURE: I understand that, once information is disclosed pursuant to this signed authorization, it is possible that it may no longer be protected by the federal health privacy law (45 CFR Part 164) may not apply to the recipient of the information and therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When AML discloses mental health and developmental disabilities information protected by state law (GS 122C) or substance abuse treatment information protected by federal law (42CFR Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws.

* This authorization expires automatically in one year. The authorization may be revoked by the legal guardian at their discretion by completing the Revocation and Expiration Form found at the end of the admission package.

_____ _____
Signature of Parent/Guardian/Consumer Date

_____ _____
Signature of Witness, Position Date

_____ _____
Signature of QMHP/Designee Date

A Mother's Love
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Consumer:_____ Chart #:_____

RELEASE OF MEDICAL RESPONSIBILITY

In order for AML to provide appropriate medical and wellness care to our consumers, the following information must be provided to AML at the time of the consumer intake or before. The current Medicaid card must be provided to AML each and every month as soon as it is received by the parent or guardian, or it can be mailed directly to AML from the Medicaid Office.

_____ A current Medicaid card **or**

_____ A copy of both sides of a current insurance card

Failure to provide this information will result in our being unable to provide routine medical and wellness care, urgent care, dental, eye and other medical examinations, and medications.

In the case of an emergency, without proof of insurance coverage, the consumer will be taken to Presbyterian Medical Center Emergency Department and treated as an indigent. All bills will be sent directly to the parent or guardian.

Your signature below releases *A Mother's Love.* from all liability relating to failure to provide routine medical care to this consumer due to failure by the parent, guardian, or case manager, to provide insurance information. You will be notified of the consumer's medical needs and will be expected to arrange medical attention and payment privately.

_____ _____
Parent/Guardian Date

_____ _____
Case Manager Date

_____ _____
AML Witness Date

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Consumer:_____ Chart #:_____

MEDICAL CARE REQUIREMENTS

1. If the consumer is currently on any medication at the time of the admission, the date of the next appointment with a physician must be in place and must occur before the medication will run out. This initial appointment is the responsibility of the Case Manager.

2. After admission, if the parent or guardian is purchasing and privately paying for medications, all medications must be filled at either _____or_____.

3. After admission, all medications purchased by a parent or guardian must be bubble packed and properly labeled.

4. All medications **must** be accompanied by a doctor's order signed by the physician or a Nurse Practitioner or a copy of the prescription.

By law, we can not accept or administer any medications without a copy of the prescription or doctor order.

We will not accept or administer any medications that have been "called in" to a pharmacist.

Failure to abide by these requirements may result in consumer discharge from AML.

_____ _____
Parent/Guardian Date

_____ _____
Case Manager Date

_____ _____
AML Witness Date

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AUTHORIZATION FOR MEDICATION

I give my consent for *A Mother's Love* to administer medications to (Consumer)_____, as needed, if medication is prescribed with treatment.

I also consent to the release of information contained in the client's medical records, which might be requested by medical personnel in order to ensure the best quality care for the client.

_____ _____
Consumer (Print Name) Social Security Number

_____
Parent/Guardian (Print Name)

_____ _____
Parent/Guardian Date

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GENERAL PERMISSION FORM

Client's Name:_____

NOTE: Please initial next to each form of permission, which is being granted by the person signing this form.

_____ RELEASE FOR OFF-CAMPUS VOLUNTEER ACTIVITIES
I hereby give my permission for the above named client to participate in off-campus activities with community volunteers and/or off duty employees. I understand that all Social Workers or Administrators must approve such persons.

_____ RELEASE FOR COMMUNITY TRIPS AND ACTIVITIES
I hereby give my permission for the above named client to participate in company trips and activities. I understand that such participation would be under the supervision of persons who have been authorized by the Administrator to supervise such trips and activities.

_____ RELEASE OF PICTURES
I hereby give my permission for pictures to be taken and/or for the publication of the pictures of the above name client for the purpose of publicity releases to the public or private news media or for any reason deemed appropriate by the Administrator. The client will not be identified by name.

_____ RELEASE OF NAME
I hereby give my permission for the publication of the above named client's full name to be used for public purposes (newspapers, magazine articles, radio, pamphlets, television and /or other news media) as approved by the Administrator.

_____ RELEASE FOR VISITATION
I hereby give my to the facility to allow the above named client to participate on day and overnight visits to the persons listed below. The names listed below which are circled shall not be permitted to visit or be visited by the above named client.

_____ RELEASE OF CLIENT FUNDS
I hereby give my permission to the facility to assist the above named client in daily personal finances which consists of: transactions, withdraws and budgeting.

_____ RELIGIOUS ACTIVITIES
I hereby give my permission for the above named client to participate in religious activities: Church, Bible study, religious concert, etc. at client discretion.

_____ SPECIAL INSTRUCTIONS OR CLARIFICATIONS:
_____
_____
_____
_____

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APPROVED INTERVENTIONS & INFORMED CONSENT OF CLIENT'S RIGHTS SIGNATURES

The following interventions have been approved for use by AML's Programs. Some of these interventions may result in a restriction of client rights.

- Recognized methods of therapeutic holds

I have been informed of the following information:

- The purposes, goals and reinforcement structure of any restrictive behavior management system that is allowed;
- Potential use of restrictive interventions; and
- Notification provisions of emergency use of restrictive intervention procedures.

_____ I understand that as the legally responsible person of the minor client or incompetent adult mentioned above, I may be notified of any use of restrictive interventions.
_____ I do request that _____ be notified at this address:
_____
_____

_____ I do not request that an individual be notified.

_____ I understand that as a competent adult I may designate a person to be notified of each use of restrictive interventions.
_____ I do request that _____ be notified at this address:
_____
_____

_____ I do not request that an individual be notified.

_____ _____
Legally Responsible Person – Signature Date

_____ _____
Client – Signature Date

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This is a consent form giving *A Mother's Love* permission to take client: _____ to any activities that may be out of ***ALAMANCE COUNTY*** during her stay with A Mother's Love.

_____
Parent/Guardian Signature

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Burlington, NC 27217

CONSUMER RIGHTS

Law Guarantees Your Rights
Unless you have been declared incompetent by a court, you have the same basic civil rights and remedies as other citizens, including the right to buy or sell property, sign a contract, register and vote, sue others who have wronged you, and marry or get a divorce. You also have other rights guaranteed by NC General Statures, Article 3, including the right to dignity, privacy, humane care and freedom from physical punishment, abuse neglect and exploitation. It is the responsibility of the program that you are receiving services from to provide you or your legally responsible person a written summary of your rights within your first three visits to the agency (or your first 72 hours if you are in a 24 hour facility).

The Right To A Treatment Plan
A written treatment plan, based on your individual needs, must be implemented within 30 days of admission. You have the right to treatment in the most normal, age-appropriate and least restrictive environment possible. You have the right to take part in the development and periodic review of this plan. You are entitled to review your treatment plan and obtain a copy of it from your therapist or medical records.

Right To Be Informed About Medications
You have the right to have medication administered in accordance with accepted medical standards and upon the order of a physician. When medication is needed, you have the right to receive it in the lowest possible therapeutic dose. You cannot be treated with experimental drugs or procedures without your written permission and without being informed of the risks, benefits and alternatives. You may refuse to take medication; however, you will be informed of the risks of doing this. Medication cannot be used for punishment, discipline or staff convenience.

Right To Refuse Treatment
Before you agree to your plan, you will be informed of the benefits of risk involved in the services you will receive. You have the right to consent to treatment and may withdraw your consent at any time. If you have asked to receive services, you always have a right to agree or refuse any specific treatment. The only time you can be treated without your consent is in an emergency or if you are a minor and your parents have given permission.

Right To Know Treatment Costs
Fees for services should be discussed with you at the first visit. If this does not occur, please inform us. A listing of charges for services is available upon your request. Please see AML administrators for more information.

Right To Be Informed Of Rules
You have the right to be informed of rules that you are expected to follow in a particular facility and possible penalties for violation of the rules. This information will be provided when you enter the program. You have the right to be free from unwarranted suspension or expulsion from programs and services. If you are discharged from a facility, you are entitled to a copy of your discharge plan.

CONSUMER RIGHTS (continued)

Your Rights In A 24-Hour Facility:
When you receive care in a 24-hour facility, you have additional rights. You must be informed of these rights within 72 hours after entering the facility.

You have a right to dignity, privacy, and humane care.

- This includes access to: daily bath or shower & daily shave (if necessary)
- Services of a barber or beautician
- Articles for personal grooming and hygiene
- Bathtubs, showers and toilets which ensure privacy and are adequate for clients with mobility impairments.

The facility will try to provide a quiet atmosphere for sleep during scheduled sleeping hours and accessible to you for periods of personal privacy. You may decorate the room that you reside in within limits. The facility will make every effort to protect your personal clothing and possessions, including assisting you to keep an inventory if you desire. If you remain in a 24-hour facility for more than 30 days the facility shall encourage and assist you to place your money in outside accounts or fellow agency procedure for internal personal account funds.

Some of your rights may be restricted by a qualified professional.
We may only restrict these rights for reasons related to your care of treatment. When your rights are restricted, the reasons must be written in your treatment plan and reassessed at least weekly. The restriction must be removed after 30-days unless a qualified professional writes into your record a reason for it to be renewed. If and when the facility restricts your rights, you have a right to have an advocate or someone you designate informed of this.

Rights which may be restricted by the facility includes:

- Your right to make and receive confidential telephone calls, long distance at your own expense.
- Visiting hours six days daily between 8am and 9pm with 2 of those hours after 6pm.
- Communicate and meet, under supervision, with other individuals who want to meet and communicate with you.
- Make visits outside the facility, unless commitment proceedings or court orders otherwise prohibit.
- Be out of doors daily and have access to regular physical exercise.
- Keep and use personal possessions and clothing, except as prohibited by law
- Participate in religious worship
- Have access to reasonable sums of your own money
- Retain a drivers license
- Have individual storage space

CONSUMER RIGHTS (continued)

The right to privacy.
You have the right to be free from any unwarranted search of your personal property. At the time of admission to a 24-hour facility, staff may search you and your belongings to prevent dangerous or illegal substances from being brought into the facility. The facility itself may be searched if dangerous or illegal substances are reasonable believed to be present, and staff may search clients who are minors. Should search and seizure apply to a program from which you are receiving treatment, the specific procedures will be explained when you enter the program.

Right not to be abused
At the time of admission to a specific program, you will be informed of the types of interventions that are approved for use by that program. The program cannot administer any potentially painful procedure or stimulus to reduce the frequency or intensity of a behavior and at not time is corporal punishment allowed. Employees must protect clients from harm and report and form of abuse, neglect or exploitation. In an emergency situation, if your behavior is dangerous to yourself or others or substantial property damage, or if we determine - based on very strict rules - that is necessary for your care, an unauthorized facility nay use restrictive interventions such as physical restraint, therapeutic holds or exclusionary time-out. A number of special safeguards must be in place when these interventions are used or when these interventions such as restraint, seclusion or isolation time-out. A number of special safeguards must be in place when these interventions are used and you or your guardian has a right to request that a designated person be notified. The gravity of some emergencies may require law enforcement assistance of initiation of involuntary commitment procedures. Strict compliance with regulations is also necessary when interventions such as, withdrawing or delaying access to possessions, taking away items, halting scheduled activities, or over-correction are used. Facilities using protective devices to provide support or enhance safety must comply with certain strict safeguards. These interventions and devises may never be used as retaliation, for the convenience of staff, or in a manner that causes harm or undue discomfort.

Right to make a complaint
If you are dissatisfied with residential services rendered through AML you have the right to state a complaint or file a grievance at any time. Before stating a written complaint, we urge you to first discuss the matter with staff of the program providing the service and allow them the opportunity to help resolve it. If this is unsuccessful, we encourage you to complete and forward to us a complaint for which you may request from staff of AML.

CONSUMER RIGHTS (continued)

Special rights if you have mental retardation.
If your primary need is related to the fact that you have mental retardation and are placed in a residential facility, you are entitled to assistance in finding another place to live if your original placement can no longer serve you. This right exists unless you have broken the rules you agreed to follow or if we offer another place that can meet your needs and refuse to offer. The facility must give you and your legal guardian and this agency 60 days advance notice if it intends to discharge you. This right does not apply if you live in a privately operated IC-MR facility.

Right to make instructions for your treatment in advance.
In the event that you become more incapacitated and unable to make decisions about your treatment you may prepare a document, which outlines your intentions for your treatment, and a person to make decisions based upon your restrictions.

Certain rights to appeal.
If you have Medicaid, you have the right to request an appeal hearing if you are denied a requested service or if current services are reduced, suspended or terminated.

Certain rights may not be restricted by the facility.
The law guarantees that certain of your rights may be exercised at all reasonable times. Adults have the right to contact and communicate with a lawyer, your own doctor, or other private professionals (at you own expense)

- Contact and consult with a client advocate
- Send and receive sealed mail and have access to postage, writing materials and staff assistance.
- Receive necessary medical treatment if you are sick (you or your insurance may be billed for medical care beyond the facility's regular service).

Minors are entitled to the same rights to send and receive mail and have access to postage, writing materials and staff assistance may be restricted. Minors are additionally entitled to communicate and consult with parents, guardians or legal custodians; proper adult supervision and guidance; opportunities for normal maturation; educational and vocational services; appropriate structure, supervision and guidance; and treatment and habilitation separate from adults, where practical and unless treatment needs dictate otherwise.

CONSUMER RIGHTS (continued)

You have the right to confidentiality.
The confidentially of your care and treatment is protected by law. Except as allowed by law and agency regulations, your records and other information about you will not be released without your written permission. Circumstances under which we may be required to share information with another about your services include:

- If you give permission we may share information with any person that you name.
- Your next of kin may be informed that you are a client, if it is in your best interest. With your permission, you next of kin, a family member with a legitimate role in your service, or another person whom you name may be given other information about your care.
- A client advocate may review your record when assigned to work on your behalf.
- The court may order us to release your records.
- Our attorney may need to see your file because of legal proceedings
- Additionally, another public agency may need to receive your files when your care is transferred.
- If you become imprisoned, we may share you file with prison officials.
- In an emergency, another professional who is treating you may receive your records.
- A physician or other professional who referred you to our facility may receive your files.
- If we believe that you are a danger to yourself or to others, or if we believe that you are likely to commit a crime, we may share information with law enforcement.

Special Rules May Apply if you have a legal guardian appointed, are a minor, or are receiving treatment for substance abuse.

You have the right to see your own records except under certain circumstances, specified by law. You have the right to have those circumstances explained to you.

A Mother's Love
1227 Westmoreland Drive
Burlington, NC 27217

DESTRUCTION OF PROPERTY FORM

The consumer or legal guardian shall be financially responsible for all damages to property.

_____ _____
Consumer Signature Date

_____ _____
Guardian Signature Date

A Mother's Love
1227 Westmoreland Drive
Burlington, NC 27217

CONSENT FOR PLACEMENT

I, _____ as legal guardian for

_____ do hereby agree that he/she will be

placed in the care of A Mother's Love Homes for Children, LLC. and its agents on

_____. I also agree that I will be responsible for any financial
Month Day Year

obligations not covered by insurance, Medicaid, SSI, or Medicare.

_____ _____
Guardian Date

_____ _____
Case Manager Date

_____ _____
Agency Supervisor Date

A Mother's Love
1227 Westmoreland Drive
Burlington, NC 27217

Consumer Name:_____ Consumer Number:_____

CONSUMER RIGHTS POLICY ACKNOWLEDGEMENT

I have read, or someone has read to me, my rights as a client at *A Mother's Love* facility. I understand what my rights are, and have been given the opportunity to have each right explained to me. I have received a copy of my consumer rights for my records.

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

_____ _____
Staff Signature Date

_____ _____
Staff Signature Date

_____ _____
Staff Signature Date

_____ _____
Case Manager Signature Date

_____ _____
Social Worker Signature Date

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VERIFICATION OF CLIENTS CRISIS PLAN

_____	_____
DSS Worker Signature	Date
_____	_____
Case Manager Signature	Date
_____	_____
Client Signature	Date
_____	_____
Parent/Guardian Signature	Date
_____	_____
AML Administrator Signature	Date
_____	_____
AML Administrator Signature	Date
_____	_____
Social Worker Signature	Date
_____	_____
BMT Supervisor	Date

Revision Date:_____

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Burlington, NC 27217

TECHNIQUES FOR DE-ESCALATING BEHAVIORS AND RENDERING CONSEQUENCES (LEAST RESTRICTIVE INTERVENTION)

1. Prompts
2. Redirect
3. Re-emphasize Behavior Management System
4. Look at Least Restrictive Interventions
    a. Point Freeze
    b. Deduction of points
    c. Deduct time off telephone & bedtime
    d. Extra Chores
    e. Role Play & Reverse role play
    f. Personal time in room away from attention seeking behavior
    g. Contact third party AML personnel to consult with consumer during crisis.
    h. Contact parent or legal guardian by phone to assist in de-escalation process.
    i. Deduct home visit time.
    j. Contact law enforcement for support if matter is out of control.

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DRESS CODE

- Everyone must wear shoes.
- No provocative dressing or clothing that reveal stomach, undergarments (underwear/camisole/ cleavage) etc. Pants must be worn up in the waist area. No sagging or revealing backside.
- Shirt must be on at all times
- No leaving the bathroom/bedroom wearing only a towel or a blanket.
- Modest Jewelry (No Piercings except for earlobe) all others have to be removed before admission. No additional piercings while in the program. No nose Jewelry / rings piercing or not.
- Prior tattoos are allowed however no additional tattoos are allowed once admitted into program
- **No Razors, cream hair removers only!**
- **Gang related materials, clothing signs or bandanas are prohibited (not allowed)**
- **Chemical use including hair coloring is not allowed to be done by consumers. Parental / guardian permission is required (written statement) for modest hair coloring.**

LAUNDRY

- Each resident will be issued a separate day to wash their laundry. If the need occurs, staff will assist in washing clothes. **The clients will only be permitted to wash clothes on the day that is selected for them. There will be no exceptions!**
- Laundry is to be completed no later than 9:00 pm.
- Linen can be washed on Sundays
- _____
  _____
  _____
  _____

_____

Consumer Signature **Date**

_____

Parental/ Guardian Signatures **Date**

_____

AML Staff **Date**

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Burlington, NC 27217

MEDICATION ORDERS

Client: _____ Record Number: _____

Allergies: _____

Drug Store: _____
(to be completed by residential staff)

The physician should list all prescribed medication. If psychiatric medication from this physician is not listed, he/she should not be getting it. The primary care physician may be prescribing additional medication. Staff should list prescription under medication.

Date: _____

List below the current psychiatric medications for this child:

Medication / Dosage Directions/ Refills

1. **5.**

2. **6.**

3. **7.**

4. **8.**

Comment(s):
_____
_____
_____
_____
All psychiatric medications are to be continued until changed.

Next appointment: _____
Date and Time

Physician's Signature/Phone Number: _____

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Burlington, NC 27217

CONSENT FOR SCHOOL PLACEMENT

I, _____ as legal guardian for_____ do
(Parent/Legal Guardian) **(Consumer)**

hereby give *A Mother's Love* permission to enroll my

child_____ at _____ in
(Consumer) **(School Name)**

_ *Alamance County* _ I further agree that he/she will reside at

1227 Westmoreland Dr, Burlington, NC 27217 **and that _____will be**
(Consumer)

placed at *A Mother's Love* on_____.
(Date)

_____ _____
Guardian **Date**

_____ _____
***A Mother's Love* Rep.** **Date**

A Mother's Love
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Burlington, NC 27217

	REVOCATION OF EXPIRATION	

Sign below ONLY if you are revoking your Authorization.

I understand that with certain, I have the right to revoke this authorization at any time. [If I want to revoke this authorization, I must do so in writing.] The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, have been explained.

Signature of Consumer: _____ Date: _____

Please Print Name of Consumer: _____

If not revoked earlier, this authorization expires automatically upon

_____

Date or event that relates to consumer or the purpose of the use or disclosure

Or one year from the date signed, whichever is earlier.

	NOTICE OF VOLUNTARINESS	

I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that AML cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits on my refusal to sign.

	SIGNATURES	

I have read and understand the information in this authorization form.

Signature of Consumer:	
Please print name:	Date:

Signature of Authorized Representative:	
Please print name:	Date:
Please explain Representative's authority to act on behalf of the Consumer: _____ _____	

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Burlington, NC 27217

Record of Disclosure of Information

_____ _____
Client Name Client Number

_____
Date of Birth

_____
Date of Disclosure Time of Disclosure

Information Disclosed To:

Name: _____
(Physician, Hospital, Agency, Clinic, LAB, Radiology Center or Other Healthcare Provider or Individual)

Address:_____

City, State, Zip: _____

Information Disclosed By:

- **E-mail**
- **Fax**
- **Orally**
- **Data Transfer**
- **First Class Mail**
- **Authorization on File?**

Authorization Date: _____

Authorization Expiration Date: _____

Reason for Disclosure:
_____
_____

Specific Information Disclosed:
_____
_____

_____
Printed Name of Individual Making Disclosure

_____
Signature of Individual Making Disclosure Date

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HIPPA Regulations

The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), also known as HIPPA, was enacted as a Congressional attempt to reform healthcare. The purpose of the Act is to:

- Improve portability and continuity of health insurance coverage in the group and individual markets;
- To combat waste, fraud, and abuse in health insurance and health care delivery;
- To promote the use of medical savings accounts;
- To improve access to long-term care services and coverage;
- To simplify the administration of health insurance; and
- Other purposes

Title I of the HIPPA law deals with health care access, portability, and renewability with the intention of protecting health insurance coverage for workers and their families when they change or lose their jobs. Title II of the law, also known as "Administrative Simplification," deals with preventing health care fraud and abuse.

The "Administrative Simplification" aspect of that law requires the United States Department of Health and Human Services (HHS) to develop standards and requirements for maintenance and transportation that identifies individual patients. These standards are usually referred to as "HIPPA Regulations."

These regulations are designed to:

- Improve the efficiency and effectiveness of the healthcare system<by standardizing the interchange of electronic data for specified administrative and financial transactions; and
- Protect the security and confidentiality of electronic health information.

The requirements outlined by the law and the regulations promulgated by DHHS are far-reaching. Healthcare organizations that maintain or transmit electronic health information must comply. This includes health plans, health care clearinghouses, and healthcare providers who submit claims electronically. After each final regulation is adopted, small health plans have 36 months to comply. Others, including healthcare providers, must comply within 24 months.

The HIPPA transaction rules will require that everyone use the same format to transmit health-related information. Claims submission, claims status reporting, referral certification and authorization, and coordination of benefits will be affected. What does this mean for medical practices? Practices will have to ensure that their software vendors have implemented the required HIPPA changes so they can send and receive information using the standard formats. Because most software vendors already use the standard formats, this regulation shouldn't have much impact on daily practices, except perhaps to make electronic data interchange preferable to (i.e., less expensive than) paper processing for providers and health plans alike. HIPPA has been instituted to provide greater protection of patient confidentiality, the regulations will require that you take a number of administrative measures to ensure that any patient-identifiable information, referred to by HIPPA as "protected health information" (PHI), in your practice is secure.

HIPPA's purpose, regulation and functioning have been explained to me.

_____ _____
Signature of Consumer Date

_____ _____
Signature of Staff/Witness Date

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1227 Westmoreland Drive
Burlington, NC 27217

AUTHORIZATION FOR USE AND DISCLSOURE OF PROTECTED HEALTH INFORMATION 45 CFR Parts 160 and 164; 42 CFR Part 2, NCGS 122C

Consumer Name:	Record #:	DOB:

I, _____ authorize _____
Consumer or Consumer's legal representative — Agency or Person authorized to use /disclose the information

To release and exchange information to : **A Mother's Love**

- I authorize A Mother's Love to release & exchange information to the above in my client record to the above documented organization/person.

the following protected information: Service order, service plan, assessments, evaluations, doctors, Notes, medication
Provide specific meaningful description of the information to be used/disclosed

Sheet, face sheet, Crisis Plan, MR2, NC TOPPS, and authorizations for FL2, Signature pages, Diagnostic Assessments, Treatment Plan and all accompanying pages.

I understand information disclosed regarding my treatment may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcohol abuse, or Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

The purpose of this disclosure is to _____
Describe purpose of the requested use or disclosure

_____

REDISCLOSURE: Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 CFR Part 14) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient form redisclosing it. Other laws, however, may prohibit redisclosure. When this agency discloses mental health and developmental disabilities information protected by state law (NCGS 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient of the information that redisclosure is prohibited excepts permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION: I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the A Mother's Love Notice of Privacy Practices, a copy of which has been provided to me.

If not revoked earlier, this authorization expires upon: _____

NOTICE OF VOLUNTARY AUTHORIZATION: I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that A Mother's Love cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits on my refusal to sign unless the provision of health care solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party.

_____ _____
Signature of Consumer — Date

_____
Print Name

_____ _____
Signature of legally responsible person/personal representative — Date

_____
If required, please explain representative's authority to act on behalf of consumer.

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Burlington, NC 27217

Elopement Policy

I, _____, understand that if my child _____ elopes from the residential premises while in the community or while on therapeutic leave three times, immediate discharge from the program will be warranted, 30 days from the last elopement date. I, _____, understand this discharge will be carried out due to safety concerns of keeping my child safe.

Parent /Legal Guardian Signature:_____ Date:_____

Client Signature: _____ Date:_____

Staff Signature: _____ Date:_____

A Mother's Love
1227 Westmoreland Drive
Burlington, NC 27217

Contact Information for Group Home

Kizzy Brown
336-438-0400
amotherslove.mhs@gmail.com

Cassandra Bradley
615-497-2333
amotherslove.mhs@gmail.com

Student Name:	
DOB:	
Grade of Student:	
Prospective School:	
Last School Attended:	
Parent/Legal Guardian:	
Address of Guardian:	
Phone Number:	
County of Residence of Legal Guardian	

List of all agencies involved with student:

- A Mother's Love
-
-
-