3966 Warrensville Ctr. Rd.
Warrensville Heights OH, 44128
Phone: 440-340-5086
Fax: 440-340-5286
oh@restoreoutreachcenter.com

Intake/Referral Form

Demographic:

Date of Referral: _____

Client Name: _____DOB: _____Age: _____

Grade: _____Gender: _____Race: _____Ethnicity: _____

Medicaid Number: _____Health Plan: _____

Social Security Number: _____

Parent/Guardian Name: _____Relationship: _____

Contact Information:

Phone Number: _____Alternate Number: _____

Address: _____

City: _____State: _____Zip Code: _____

Education: Is this client enrolled in school:(YES / NO) School Name: _____

Presenting Problem(s): Please check all that apply

☐ Anxiety	☐ Criminal Behavior	☐ Constant Restlessness	☐ Cutting Self	☐ Defiance
☐ Depression	☐ Destructiveness	☐ Difficulty Concentrating	☐ Fidgety	☐ Fighting
☐ Fire Setting	☐ Self Harm	☐ Hurting animals	☐ Lying	☐ Low Self Esteem
☐ Phobias	☐ Running Away	☐ Suicidal	☐ Temper Tantrums	☐ Verbal Threats

Past Treatment:

Has the client been diagnosed with a behavioral or mental disorder previously? _____
If "Yes", please explain? _____
Is client on any prescribed medication for this diagnosis? _____
Has the client been enrolled in any other agency/program? _____

Referral Source: _____

Assessment appointment - Date: _____at _____

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Member Orientation Form

As a member, parent, or legal guardian of a member of ***Restore Outreach Center,*** you can expect to be instructed or given written information regarding the following, upon admission to ***Restore Outreach Center's*** Mental Health Program

1. Member Rights and Responsibilities
2. Grievance and Appeal Procedures
3. Communication/input policies regarding:
    a. Quality of care
    b. Outcome achievement
    c. Member satisfaction

4. Explanation of ***Restore Outreach Center's***
    a. Mission/philosophy
    b. Services, activities, and therapeutic interventions
    c. Expectations
    d. Hours of operation
    e. 24-hour on call policy
    f. Code of ethics
    g. Confidentiality policy
    h. Requirements for follow-up for mandated members, regardless of his/her discharge outcome.

5. Explanation of any and all financial obligations, fees, and arrangements for services provided by the organization.
6. Orientation with ***Restore Outreach Center*** facilities, including emergency exits, fire suppression equipment, and first aid kits.

7. ***Restore Outreach Center*** policies regarding.
    a. Smoking
    b. Illicit or licit drugs
    c. Weapons
    d. Abuse

8. Identification of service coordinator
9. Program rules that identify:
    a. Any restrictions the program may place on members.
    b. Events, behaviors, or attitudes that may lead to the loss of rights or privileges that have been restricted.

10. Education regarding Advanced Directives, where appropriate
11. Identification of the purpose and process assessment
12. A description of how the treatment plan will be developed.
13. information regarding transition of criteria and procedures

Client/Parent or Legal Guardian: _____
Print

_____ _____
Signature Date

Name: _____ Medicaid ID:_ _ _ _ _ _ DOB:_ _ _ _ _

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Recipient's Rights & Responsibilities Acknowledgment

All recipients have the following rights:

1. The right to privacy, security, and respect of property.
2. The right to voice a complaint or concern regarding care or service.
3. The right participates in all aspects of care/services and planning of care/services.
4. The right to refuse all or parts of his/her care to the extent permitted by law.
5. The right to have resuscitative services withheld and life-sustaining treatment withdrawn.
6. The right to information about the cost of services that will be billed to his/her insurance(s) and/or self (verbally and in writing).
7. The right to information about the value or purpose of any technical procedure that will be performed, including the benefits, risks, and who will perform the task/ procedure.
8. The right to information about ownership or control of the agency.
9. The right to review records.
10. The right to 24-hour crisis intervention
11. The right to protection from abuse, neglect, retaliation, humiliation, and exploitation. However, Restore Outreach Center, LLC reserves the right to include emergency intervention and other special treatment interventions are used, Restore Outreach Center, LLC assures that they will be administered with consideration given to the physical, developmental, and abuse history of the person served.

Important- If at any time the staff member becomes aware of an infringement or violation of recipients rights it is the responsibility of that employee to report that infringement violation directly to the Clinical Director of the program coordinator as quickly as possible. Furthermore, all such incidents must be documented on a Critical Incident Form immediately.

All recipients have the following responsibilities, unless otherwise stated by the agency upon enrollment:

- The recipient is responsible for attending group meetings in the community and agency.
- The recipient is responsible for allowing agency staff to rent the recipients home for home visits. Recipients must take reasonable efforts to schedule and meet with agency staff for regular home visits.
- The recipient is responsible for meeting with psychiatrist once a month or as scheduled.
- The recipient is responsible for preparing for transportation during group settings and psychiatrist visits.
- The recipient is responsible for signing the Individualized Service Recovery Plan at the start if services and every three months thereafter with the licensed mental health professional (LMHP) and Psychiatrist
- The recipient is responsible for obtaining medicine as prescribed by the psychiatrist.

Name: _____ **Medicaid ID:**_____ **DOB:**_____

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- The recipient is responsible for ensuring compliance in taking prescribed medications and reporting side effects on the medications to the Licensed Mental Health Professional/Psychiatrist
- The recipient is responsible for calling the Licensed Mental Health Professional if moving (change of address/phone number), hospitalized (for any reason), or leaving the local area for an extended period to ensure continuity of care.

By signing below, I acknowledge that the staff has explained my Rights and Responsibilities as a client of Restore Outreach Center, LLC.

Recipient's Name: _____

Recipients Signature: _____ Date:_____

PARENT/GAURDIAN IF RECIPENT IS UNDER AGE 18

I certify that I have explained the Rights and Responsibilities of Restore Outreach Center

Authorized Representative: _____ Date: _____

Name: _____ Medicaid ID:_____ DOB:_____

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_____ (Date)

Re: Release of Information /Care of Coordination

Client: _____

DOB: _____

Parent/Guardian: _____

Dear_____, (provider)

_____(client) had identified you as their provider. In my work with the client, we have discussed the importance of coordinating care across health care professionals. In response to this discussion, the client above has signed an authorization form allowing us to exchange pertinent information with you regarding their care. Please note that Restore Outreach Center (ROC) is a behavioral health provider, and we are currently providing community-based mental health services to the client. If you have further information that you think might assist us in better meeting this individual's clinical needs, please feel free to contact me directly. I look forward to our working together on an integrated approach for an optimal treatment outcome. Please save this correspondence and the attached consent in your records.

Respectfully,

Clinical Supervisor on Call
Restore Outreach Center, LLC
216-304-7848 (Phone)

Name: _____ Medicaid ID:_____ DOB:_____

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Tele behavioral Health Informed Consent

Tele-behavioral health (Tele-therapy) means the use of real-time audiovisual communications of such quality as to permit accurate and meaningful interaction between a provider of the service and the person(s) service is:

Tele-behavioral health allows clients to access behavioral health care using audio-video interface such as videoconferencing. Asynchronous modalities that do not have both audio and video elements are considered telehealth.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

Improved access to behavioral health care by enabling a client to remain in his/her home or office. Improved convenience for the client.

- More efficient management of behavioral health care within the community setting.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of tele-behavioral health. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for effective communication between the client and the behavioral health professional. Effective communication is vital to the provision of behavioral health services by the behavioral health professional.
- Cultural and/or language differences between the client and the behavioral health professional may affect communication and service delivery.
- Delays in behavioral health assessment and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete medical records may result in judgmental errors by the behavioral health professional.

By signing this form, I understand the following:

Name: _____ **Medicaid ID:**_____ **DOB:**_____

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1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to tele-behavioral health and that no information obtained in the use of tele-therapy which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of tele- behavioral health in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained in the course of a tele-behavioral health interaction and may receive copies of this information for a reasonable fee.

4. I understand that no video and/or audio recordings of tele-behavioral health sessions will be made.

5. I understand that a variety of alternative methods for the provision of behavioral health services may be available to me, and that I may choose one or more of these at any time.

6. I understand that an alternative method for the provision of behavioral health services may be used by being to.

7. I understand that it is my duty to inform my behavioral health professional of any other healthcare providers involved in my medical/ behavioral health care.

8. I understand that I may expect the anticipated benefits from the use of tele-behavioral health in my care, but that no results can be guaranteed or assured.

9. I understand that Restore Outreach Center, LLC cannot ensure confidentiality at the site where the client is located and when unapproved equipment software is used by the client, when tele- behavioral health procedures are not followed by the client.

10. I understand that Restore Outreach Center, LLC is not responsible for overages on client data usage plans, when Wi-Fi is not used by the client. I understand that my behavioral health professional providing tele-behavioral health is a qualified behavioral health professional with specialized training in the provision of distance behavioral health.

11. I understand and accept that emergency services are not limited, services are not included in tele behavioral health services. If I am experiencing an emergency, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts, I can contact the National suicide Prevention lifeline at 1-800-273-8255.

12. I understand that in times of crisis outside of normal work hours of my behavioral health professional I may call the Mobile Crisis Hotline at 234-334-1880 or call 911.

- My ROC clinician will explain how the tele behavioral health service is performed and how it will be used for my treatment My ROC clinician will also explain how the services (s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology. I understand that it is my duty to inform my ROC clinician of electronic interactions regarding my care that I may have with other health care providers.

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- If during my Tele behavioral health session, I am unable to complete the session for any reason, I will immediately notify ROC staff. Every attempt will be made to preserve my scheduled appointment. However, if I am unable to complete the service, ROC will reschedule my appointment as soon as possible with an available ROC clinician.

Client Consent to the Use of Tele-Behavioral health

I hereby consent to engaging in teletherapy with Restore Outreach Center. I understand that "teletherapy" includes the practice of behavioral health care, delivery, diagnosis, consultation, treatment, and education using interactive audio, video, or data communications of my medical/behavioral health information, both orally and visually, to Restore Outreach Center, LLC via a teletherapy service such as Doxy.Me, Zoom, etc. (a HIPPA compliant video platform service).

I have read and understand the information provided above regarding tele-behavioral health, have discussed it with my behavioral health professional as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of tele-therapy in my medical care. I hereby authorize Restore Outreach Center, LLC to use tele- behavioral health in the course of my behavioral health diagnosis and treatment.

_____ I consent to participate in tele behavioral health online services under the conditions described in this document.

_____ I do not consent to participate in tele behavioral health services and understand that I will not have consistent contact with my advocate or counselor until face-to-face sessions resume. If I need support or become triggered during this time, I can call the National Suicide Prevention hotline at 1-800-273-8255 or text the word HOMB to 741741. I can also report to the nearest emergency room if I experience any suicidal and or homicidal ideations.

_____ _____
Client or Parental/Legal Guardian Signature **Date**

I certify that I have explained all rights and responsibilities to the client.

_____ _____
Staff Signature **Date**

Name: _____ **Medicaid ID:**_____ **DOB:**_____

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R.O.C

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I, the recipient/guardian of _____, subject to the conditions set forth below. I consent to receive such medical treatment and/or surgical procedures necessary in the event of an emergency, and to assume liability for medical acceptance expenses involved. This authorization extends to my participation in any activity sponsored by Restore Outreach Center, as a whole, or by workers within each program site.

Should a medical emergency arise during my participation in a Restore Outreach sponsored event, I understand that reasonable efforts will be made to contact me or my designated emergency contact at the numbers listed below. If it is believed my life or health may be adversely affected by the delay that an attempt to contact me or my designated contact could cause.

I consent to the administration of medical treatment and/or surgical procedures as deemed necessary by the medical doctor and/or facility and to the immediate administration of life-sustaining measure (s) deemed necessary under the circumstances.

HEALTH INFORMATION:

Doctor's name Clinic: _____ Phone: _____Fax: _____
Allergies: _____
Medications: _____
Medical Program (Diabetes, Epilepsy, etc.): _____ __
Does the client have an Advanced Directive? If yes, please provide Restore Outreach with a copy?
Does the client have any communication barriers which may make it difficult to understand him/her?
If yes, please explain:
Does the client have a history of Substance Abuse? Yes or No If yes, please explain:

INSURANCE INFORMATION:

Company: _____ __
Policy#: _____ __
Policy Holders Name and Relationship to Child: _____ __

CONTACT INFORMATION:

Recipient Name: _____
Parent/Guardian Name: _____ __
Address: _____ __
Home Phone#: _____ Alternative Phone#_____ __
Alternate Contact Person: _____Relationship: _____
Address: _____
Home Phone#; _____. Alternative Phone#: _____
Preferred Doctor/ Medical Facility: _____
Phone: _____ __

Signature of Recipient/Parent or Guardian: _____ Date: _____

Name: _____ **Medicaid ID:** _____ **DOB:**____ _

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Limits on Client Confidentiality

We are required to disclose confidential information if any of the following conditions exist:

1 . You are a danger to yourself or others.
2. You seek treatment to avoid detection or apprehension or enable anyone to commit a crime.
3. Your therapist was appointed by the courts to evaluate you.
4. Your contact with your therapist is for the purpose of determining your sanity in criminal proceedings.
5. Your contact is for the purpose of establishing your competence.
6. Your contact is one in which your psychotherapist must file a report to a public employer or as to disclose information required to be recorded in a public office, if such report is open to public inspection.
7. You are under the age of 16 years and are the victim of a crime.
8. You are a minor and your psychotherapist reasonably suspects you are the victim of child abuse.
9. You die and the communication is important to decide and issue concerning deed or conveyance, will or other writings executed involving you affecting as interest in property.
10. You file sui against your therapist for breech of duty or your therapist files suit against you.
11. You have filed suit against anyone and have claimed mental emotional damages as part of the suit. You waive your rights to privacy or give consent to limited disclosure by your therapist.
12. Your insurance company paying for services has the right to review all records.

Client Signature:_____ Date: _____

Staff Signature:_____

Name:_____ Medicaid ID:_____ DOB:_____

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Authorization for Release of Information

I _____ (consumer/guardian) understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws.

I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may o longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS-related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I also understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determination prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I,_____ authorize Restore Outreach Center, LLC effective _____, and to expire six months from the beginning date, to disclose and/or obtain information from:

_____

_____

_____

The following information from Restore Outreach Center:

Name:_____ Medicaid ID:_____ DOB:_____

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☐All Listed Below
☐Case Coordination
☐Psychiatric Evaluation
☐Treatment Plan
☐Medical Information
☐Psychological Testing
☐Other: _____

☐Medical Records
☐Assessment
☐Diagnosis
☐Discharge Summary
☐Participation in Treatment
☐Educational Information

Purpose

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Restore Outreach Center, LLC. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

_____ _____

Print & Signature of Client Date

_____ _____

Print & Signature of Parent/Guardian Date

_____ _____

Print & Signature Clinician Name/Credentials Date

Name:_____ Medicaid ID:_____ DOB:_____

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Grievance Procedure

Policy

It is the policy of Restore Outreach Center, LLC to maintain resolutions records of client grievances for at least two years.

It is the policy of Restore Outreach Center, LLC Services to establish guidelines of the timely processing of client grievances as they pertain to Restore Outreach Center, LLC Clients Rights Policy.

It is the policy of Restore Outreach Center, LLC to ensure that the program participants have the right to file grievances concerning the services they receive a copy while a program participant.

It is the policy of Restore Outreach Center, LLC to appoint a designated client advocate who will assist client in filing a grievance, the client advocate will provide their name title, location, hours of availability, and telephone number included with the posting of client rights which will be posted in Restore Outreach Center, LLC front office.

Procedure

It shall further be the policy of Restore Outreach Center, LLC
to fully support the appointed Client Advocate to take all necessary steps to assure compliance with the following procedures:

1. Statement to whom the client is to give the grievance.
2. Requirement that the grievance must be put into writing; the grievance may be verbal, and client advocate shall be responsible for preparing a written text of the grievance.
3. Letter may be sent to; 5500 Ridge Rd. Cleveland Ohio, 44129. Restore Outreach Center, LLC.
4. Requirement that the written grievance must be dated and signed by the client, individual filing the grievance on behalf of the client, or have an attestation by the client advocate that the written grievance is true and accurate representation of the client's grievance.
5. Requirement that the grievance include, if available, the date, approximate time, description of the incident and names or individuals involved in the incident or situation being grieved.
6. Statement that the program will make a resolution decision on the grievance within twenty business days of receipt of the grievance. Any extenuating circumstances indicating that this period will need to be extended must be documented in the grievance file and written notification given to the client.
7. Statement that a client has the option to file a grievance with outside organization, that include, but are not limited to, the following, with the mailing address and telephone numbers for each stated:

Name:_____ Medicaid ID:_____ DOB:_____

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Board of Alcohol, drug addiction, and mental health services (ADMHS), 2012 W, 25 th St., 6th floor, Cleveland, Ohio, 44113, (216) 241-3400

Ohio Department of Mental Health and Addiction Services, 30E. Broad St. Columbus, Ohio 432 15 Suite 742, (614) 466-7264

Disability Rights Ohio 200 Civic Center Dr. Columbus, OH 43215

1-800-282-9181 TTY 1800-858-3542

Ohio Department of Human Services, Office of Civil Rights Regional Office 10,000 Bessie Cole man Dr. Chicago, IL 60666 (773) 894-2960

8. Requirement that a written acknowledgment of receipt of the grievance be provided to each grievance. Such acknowledgment shall be provided within three business days from receipt of the grievance. The written acknowledgment shall include, but not be limited to, the following:

    (a) Date grievance was received.

    (b) Summary of grievance.

    (c) Overview of grievance investigation process.

    (d) Timetable for completion of investigation and notification and resolution.

    (e) Treatment provider contact name, address, and telephone number.

Restore Outreach Center, LLC will keep records of grievances it receives, the subject of the grievances, resolutions of each and will ensure the availability of these records for review of Department of Mental Health and Addiction Services upon request. Restore Outreach Center, LLC will also summarize annually its records to include the number of grievances and resolution status for each.

Restore Outreach Center, LLC employees/volunteers/contractors will be directly notified within 24 hours through company email about of all modifications to Restore Outreach Center, LLC policies and procedures with revision dates documented with 48 hours to respond and sign documentation.
Restore Outreach Center, LLC employees/volunteers/contractors will receive a copy of Restore Outreach Center, LLC written personnel policies and procedures at the time of orientation.

Restore Outreach Center, LLC employees/volunteers/contractors will be notified via company email of all modifications in personnel policies and procedures within 24 hours and 48 hours to respond and sign documentation.

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I,_____acknowledge that the nature and services of this program have been fully explained to me, and I acknowledge I have read, understand, and have received a copy of the Client's Rights and Grievance Procedure.

I acknowledge that I have read and fully understand the rules and regulations of the program.

_____ _____
Signature of Consumer/Guardian Date

_____ _____
Staff Signature Date

Name:_____ Medicaid ID:_____ DOB:_____

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Permission to Bill the Insurance Company

I, _____ authorize staff and the representatives of Restore Outreach Center, LLC to bill the appropriate insurance company for services provided to me.

_____ _____

Signature of Consumer Date

_____ _____

Witness Signature Date

Name:_____ Medicaid ID:_____ DOB:_____

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Waiver For Client

I, _____ understand that by signing this release, I waive any and all claims against Restore Outreach Center, LLC and/or its staff for any liability including but not limited to personal/bodily injury (including death) and consumer property loss or damage during involvement in any class or activity sponsored by Restore Outreach Center, LLC. Consumer participation is voluntary, so the undersigned acknowledges the risks of potential injury associated with the physical aspects of activity participation.

_____ _____

Client Signature

_____ _____

Staff Signature Date

Name:_____ Medicaid ID:_____ DOB:_____

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Provider Selection Form

I _____ have chosen to select Restore Outreach Center, LLC as my service provider for my behavioral health services.

I have been presented with other agencies of choice and have not been coerced into choosing Restore Outreach Center, LLC as my provider.

I have also been oriented in the procedure and nature of the services that are provided by Restore Outreach Center, LLC

_____ _____
Signature of Consumer/Guardian Date

_____ _____
Staff Signature Date

Name:_____ Medicaid ID:_____ DOB:_____

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Notice of Privacy Practices

The notice describes how medical information about you may used and disclosed and how you can get access to this information. Please review it very carefully.

Restore Outreach Center, LLC HAS A LEGAL DUTY TO SAFEGUARD AND PROTECT YOUR HEALTH INFORMATTON. All employees, volunteers, staff, doctors, health professionals and other personnel are legally required to and must abide by the policies set forth in this notice, and to protect the privacy of your health information, this "protected health information' Preludes information that can be used to identify you. We collect or receive this information about your past, present or future health condition to provide health care to you, or to receive payment for this healthcare. We must provide you with this notice about our privity practices that explain how, when and why we use and disclose (release) your Protected Health Information. With some exceptions, we may not use or release any more of your Protected Health Information than is necessary to accomplish the need for the information. We must abide by the terms of the notice of privacy practices currently in effect. We reserve the right to cringe the terms of this notice and our privacy policies at any time. Any changes to this notice will apply to the Protected Health information already in existence. Before we make any change to our policies, we will promptly change this notice and post anew notice in our lobby. You can also request a copy from the contact person listed at the end of this notice at any time.

WE MAY USE AND RELEASE YOUR PROTECTED HEALTH INFORMATION for many different reasons. Below, we describe the different categories of when we use and release your Protected Health Intimation without your consent.

A. **WE MAY USE, OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPE.RATIONS.**

1. **For Treatment**. We may share your Protected Health Information among physicians, curses, psychologists, social workers, interns, and other health cate personnel who are directly involved in your health care at this clinic. For example: your primary therapist and your medication provider will share your protected health information to provide the best care for you. For external disclosures we will always ask for your authorization before we disclose your health information except in emergencies to other mental health agencies or units.

2. **To obtain payment for treatment**. We may use and release your Protected Health in order to bill-and collect payment from you for services provided to you. It is important that you provide us with correct and up to date information. For example, we may release portions of your Protected Health Information to our billing department to get paid for the health care services we provided to you. We may also release your Protected Health our business associates, such as billing companies.

3. To run our health care business. We may use your Protected Health Information internally, in order to operate our facility in compliance with health care regulations. For example, we may use your Protected Health intimation to review the quality of our services and to evaluate the performance of our staff in caring for you.

B. **WE DO NOT REQUIRE YOUR CONSENT TO USE OR RELEASE YOUR PROTECTFD HEALTH INFORMATION:**

1. When **federal, state, or** local **law;** judicial **or administrative proceedings or law enforcement agency** request your Protected Health Information. We release your Protected Health informationally when a law requires that we report information to government agencies or law enforcement personnel Specifically, we would notify the State of Ohio Child Abuse Registry about victims of child abuse, or neglect. We would also notify Enforcement officials about the following for notification and identification purposes when a crime has occurred; in missing person cases; or when ordered in a judicial or administrative proceeding.

2. **About Decedents**. We provide coroners/medical at their request, necessary information relating to an individual's death.

3. **To avoid harm**. In order to avoid a serious threat to your safety of another individual, we may provide your Protected health Information to law enforcement personnel, or to the endangered person, or to other people able to prevent or lessen such harm.

4. **For appointment reminders and health-related benefits and services.** We may use your demographic Protected Health
Information reminder that you have an appointment or to recommend possible treatment options or alternatives that may be of interest to you.

Please sign and date that you have read these Privacy Practices

R.O.C

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Phone: 440-340-5086
Fax: 440-340-5286
oh@restoreoutreachcenter.com

1. About Decedents. We provide medical at their request, necessary information relating to an individual's death.

2. To avoid order to avoid a serious threat to your safety of another individual, we may provide your Protected to law enforcement personnel, or to the endangered person, or to other people able to prevent or lessen such harm.

3. For appointment reminders and health-related benefits and services. We may use your demographic. Protected Health

Information reminder that you have an appointment or to recommend possible treatment options or alternatives that may be of interest to you.

Please sign and date that you have read these Privacy Practices

Client/Parent or Guardian Signature Date

Name: _____ Medicaid ID:_____ DOB:____ _

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How to voice your concerns about our privacy practices:

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected Health information, you may file a complaint with our Privacy Official listed below. You also may send a written complaint to the secretary of the Department of Health and Human Services

YOU WILL NOT BE PEANILIZED FOR FILING A COMPLAINT.

FOR INFORMATION ABOUT THIS NOTICE OR TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES PLEASE CONTACT **RESTORE OUTREACH CENTER, LLC'S CLINICAL DIRECTOR AT 216.304.7848**

NOTICE OF PRIVACY PRACTICES ACKNOWLDGEMENT

By signing below, I acknowledge that I have received a copy of Restore Outreach Center, LLC's "Notice of Privacy and Practices."

Client:_____
Print

_____ _____
Signature Date

Staff: _____ _____
Signature Dat

Name:_____ Medicaid ID:..... DOB:.....

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Report Child Abuse and Neglect 855 O-H-CHILD

Ohioans who suspect child abuse or neglect now only need to remember one phone number.

The Ohio Department of Job and Family Services has launched 855-0-H-CHILD (855-642-4453), an automated telephone directory that will link callers directly to a child welfare or law enforcement office in their county. Reports can be anonymous.

Please Note: All of the below information is not needed to make a report. If you are not sure you have enough information to report, always err on the safety o/the child. Children Services screens all reports to determine if there is enough information to investigate.

What information is helpful when making a report?

1. The name and address of the child you suspect is being abused or neglected.
2. The age of the child.
3. The name and address of the parents or caretakers.
4. The name of the person you suspect is abusing or neglecting the child and the address if available.
5. The reason you suspect the child is being abuse and neglected.
6. Any other information which may be helpful to the investigation; and
7. You have the option of giving your name or reporting anonymously. Giving your name can help the investigator clarify information. The agency will not give your name to the person suspected of abusing the child.

What happens after a report is made?

In Ohio, after a report is made,

1. A child protective services investigator will interview the child, family members and others as deemed appropriate.
2. The investigator determines if the child is being abused or is at risk for abuse.
3. The case may be referred to local social service agencies, or to juvenile, family, or criminal court.

For more information, please go to:

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https:/lcodes.ohio.eov/ohio-revised-code/section-2151.421

Rule 4757-5-10

(A) Mandatory reporting: All licensees, registrants, supervisors and trainees have a responsibility to report any alleged violations of this act or rules adopted under it to the counselor, social worker, and marriage and family therapist board. Also, if they have knowledge or reason to suspect that a licensed colleague or other licensee, who is not a client, is acting in an unethical way or is incompetent or impaired they shall report that practitioner to the board. All mandatory reporting shall be in writing and bear the name and license number or registration of the reporter. When client confidentiality limits the licensee's ability to provide details the licensee is still mandated to report the allegations against another licensee without breaching client confidentiality.

(B) Counselors, social workers, and marriage and family therapists are required to comply with all mandatory reporting requirements set forth in the Revised Code to include, but not limited to:

(1) Section 2305,51 of the Revised Code - Immunity of mental health professionals for reporting violent behavior by a client or patient.
(2) Section 2151.421 of the Revised Code - Duty to report child abuse or neglect.
(3) Section 510161 of the Revised Code - Duty to report abuse, neglect, or exploitation of an adult.
(4) Section 2317.02 of the Revised Code - Privileged communications; and
(5) Section 5123.61 of the Revised Code - Mandatory duty to report any abuse, neglect, other major unusual incident (MUI) for a child or adult with an intellectual disability or other developmental disability.
(6) Section 959.07 of the Revised Code -Animal abuse reporting requirements.

Client or Parental/Legal Guardian Signature _____ Date _____

Staff Signature _____ Date _____

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24-hour Crisis/Emergency Availability

After Hours/Crisis Number: 216-304-7848

POLICY: Clients will receive crisis-related services as needed, including during non- regular scheduled office hours and on weekends. Crisis services will be rendered by agency staff on a weekly rotating basis.

PURPOSE: To ensure that the emergency needs of clients are addressed in a timely manner.

PROCEDURE:

- All direct service staff and the clinical supervisors will participate in a staff rotating system to provide on-call crisis services. Staff will be on call for one week at a time.
- The rotating system will be run alphabetically (A-Z), per the last name of each staff member.
- The staff member on-call will obtain the agency cell phone for crisis services from the Office manager no later than 4:00 pm of the Friday beginning the week of on-call status.
- Orientation will activate the crisis system by calling the After flours/Crisis Number listed on this form and the client handbook, given to each client at the beginning of services by the client's primary clinician.
- Upon receiving the call from the client in Crisis, the on-call staff member must respond within thirty (30) minutes, if a more immediate response is not possible.
- The on-call staff member's role is to assess the nature of the client's status, obtaining as clearly as possible why the client is in a state of crisis as clearly as possible why the client is in a state of crisis.
- Based upon the assessment and the judgment of the on-call staff member, he/she may:
    - Handle the crisis over the phone if possible.
    - Arrange for psychiatric services and hospitalization and or direct contact to a Psychiatric facility with which the agency has a prearranged relationship.

All major behavioral and physical health crisis calls must be documented by the worker on a Critical Incident form within 24 hours and on a progress note in Clinical Advisor. Additionally, all crisis calls must be recorded in the Crisis Phone Log which must be handed in to the Clinical Supervisor at the end of the worker's on-call status.

If on-call worker has difficulty in implementing the policy or determining proper action regarding a client in crisis, the on-call worker must contact the Clinical Supervisor or, if not able to be `reached, must immediately call the Crisis Line.

Name: ---------- Medicaid ID: _____ DOB:___ _