

Fax Cover Sheet

Precious Haven, Inc.

Post Office Box 25821
Fayetteville, NC 28314
Phone: 910-868-6092
Fax: 910-868-8882

Send to: Felisha Shaw	From: Melissa McAllister
Attention:	Date: 3.7.2013
Office Location:	Office Location: 6302 Raeford Rd.
Office Number:	Phone Number: 910-868-6092
Fax Number: 910-997-8423	Fax Number: 910-868-8882

- Urgent
 Reply ASAP
 Please comment
 Please Review
 For your Information

Total pages, including cover:

Comments:

Attached is a copy of Precious Haven, Inc. intake packet for our Level III Therapeutic Foster Care Service that you have requested. Please fill out the information and fax it back to us with a copy of the consumer's PCP, Diagnostic Assessment, Discharge Plan, ITR, copy of Medicaid Card, copy of Birth Certificate, copy of Social Security Card, and any other pertinent information. Please keep in mind that our facility is a first come first served, so it is imperative that you get the following information to us as soon as possible. Our provider number for ITR is 6604463. If there are any questions or concerns, feel free to contact us at any time.

"THIS INFORMATION IS "CONFIDENTIAL AND PRIVILEGED"

"Sensitive Information....Re-disclosure is Prohibited Without Consumer Consent"

Client Record # _____

Consent Forms:

(Initial here once informed) **Restrictive Interventions**

I, give permission to the above-mentioned agency to perform restrictive intervention on when all other methods have been exhausted when trying to deescalate the above-mentioned consumer. Following the utilization of a restrictive intervention, staff shall conduct debriefing and planning with to eliminate or reduce the probability of the future use of restrictive interventions. I understand that this consent is only valid for unplanned restrictive interventions and is not invalid unless the client or legally responsible person chooses to withdraw the consent.

(Initial here once informed) **Suspension and Expulsion from Service**

I, understand that if I do not comply with the rules outlined by the agency and becomes a possible threat to others served within this agency he/she may be possibly suspended or expelled from services. I understand that this would be the agency's last result before assessing the client to see if he/she meets the criteria to discharge. However, if it results in discharge the agency will follow its due process procedure before exhausting all other means.

(Initial here once informed) **Search and Seizure**

I understand that each client shall be free from unwarranted invasion of privacy. However, I understand that searches of me/my child's living area may occur. I, also give permission to the agency to perform random planned or unplanned searches and seizures on me/my child's belongings, or property in his/her possession. I understand that each search will be documented to include, scope of search, reason for search, procedures followed in the search, description of any property found and an account of the disposition of seized property.

(Initial here once informed) **Carolina Legal Assistance**

I understand a written summary of client rights shall be made available to each client and legally responsible person. I have been informed of his/her right to contact The Carolina Legal Assistance who assumed the role of the (GACP), the state wide agency designated under federal and state law to protect and advocate the rights of person with disabilities.

(Initial here once informed) **Admissions into Services Agreement**

I understand that I shall be informed of services rendered by this agency upon admission or entry into services.

(Initial here once informed) **Agency Rules**

I understand the rules that I and/my child is expected to follow and possible penalties for violation of the rules.

(Initial here once informed) **Consent regarding Disclosure of Confidential Information**

I understand that the agency will follow its policy as it relates to protecting my rights regarding disclosure of confidential information, as delineated in G.S. 122C-52 through G.S. 122C-56.

(Initial here once informed) **Consent regarding Treatment**

I give permission to Precious Haven, Inc. to obtain a copy of my/my child's treatment / Habilitation plan and/or other information that relates to him/her in order for the agency to adequately serve.

(Initial here once informed) **Fee Assessment**

I understand that I will be responsible for fees assess by my/my child that Medicaid does not cover as it relates to the treatment of me/my child. I understand that the agency will do everything possible to avoid collection from me/my child on behalf of treatment/habilitation services rendered.

Client Record # _____

(Initial here once informed) **Grievance Procedures**

I understand that /my child has the right disclose any grievances that he/she may have as it relates to the agency. I understand that Precious Haven, Inc. will be provided a description of the assistance that the agency will be provided. I understand that the agency will be provided the results of any grievance submitted on behalf of my/my child. I understand that he/she will be given a chance to dispute the results of his/her grievance if the findings are not to his/her satisfaction. I understand that I can contact Carolina Legal Assistance who replaced (GACP/D) or the Local Mental Health LME.

(Initial here once informed) **Informed of Client Rights**

I understand and have been informed and received a copy of the Client Rights handbook. I understand the consent forms are valid unless the client or legally responsible person chooses to withdraw the consent. I have received, and had been explained my Rights to Privacy. Precious Haven, Inc. gave me a copy of the Client Rights handbook and I understand these rights, which are designed to protect the privacy of me/ and/or my child.

(Initial here once informed) **Social Integration**

I give Precious Haven, Inc. my permission to allow me/my child to participate in appropriate and generally acceptable social interactions and activities with other clients and non-client members of the community. I /my child shall not be prohibited from such social interactions unless restricted in writing in the client record in accordance with G.S. 122C-62 (e).

(Initial here once informed) **Emergency Medical Treatment**

I give Precious Haven, Inc. my permission to seek emergency care for me/my child from a hospital or physician. I also give Precious Haven, Inc. the consent to seek and sign consent for preventive and emergency medical care for my child in my absence. It is understood that Precious Haven, Inc. will attempt to contact me, or another designated responsible adult as soon as possible in the event of an emergency.

(Initial here once informed) **Disaster and Risk Management Plan**

I have been informed and received a copy Precious Haven, Inc. Disaster Preparedness Plan and Risk Management Practices. I understand the consent forms are valid unless the client or legally responsible person chooses to withdraw the consent.

(Initial here once informed) **Financial Release**

I have been informed and received a copy Precious Haven, Inc. may use confidential information about me to bill and be paid for services. I hereby consent Precious Haven, Inc. to release information to Value Options (the State of NC managed care vendor) and/or the referring Area Program.

(Initial here once informed) **Transport**

I have been informed and received a copy Precious Haven, Inc. to provide transportation to my child, and agree to hold Precious Haven, Inc. harmless for any accident/injury that results from the provision of transportation.

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If not revoked earlier, this consent shall be valid for one year from the signed unless otherwise indicated below:

(Date of expiration, if less than one year) _____ (Event, if less than one year)

Signature of Client _____ Date _____ Witness (required if symbol or mark is used by client)

Signature of legally responsible person _____ Date _____

Precious Haven, Inc.
Policy and Procedure Manual
Section # 1.k; 2.a; 2.c; 2.d; 2.e; 2.f; 5.a; 5.b; 5.c; 5.d; 8.c(5); 8.d; 8.e; 9.b(2f)

Rights of the Person
Approved: October 1, 2009

Client Record # _____

This authorization form implements the requirements for client authorization to use and disclose information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), and the state confidentiality law governing mental health developmental disabilities and substance abuse services (G.S. 122C).

Client Name: _____ Record Number: _____
Date of Birth: _____ Social Security #: _____

I, _____ authorize Precious Haven Inc to use or disclose to with

(Name of Agency or person to whom the requested use or disclosure will be made (include address/if applicable))

This data shall include (client is encouraged to initial beside data to be used or disclosed)

Assessments _____	Service Notes _____	Substance Abuse/Treatment _____
Psychiatric Evaluations _____	Service Plans/Goals _____	HIV/Aids Information _____
Diagnosis _____	Discharge Summary _____	Social History _____
Developmental History _____	Financial/Reimbursement _____	Medical History _____
PCP _____	Other _____	

Purpose of Use or Disclosure (client is encouraged to initial beside data to be used or disclosed)

At the request of the individual _____ Assessment/Evaluation
Coordination of Service _____ Court Proceedings _____ Determination of Benefits

Information requested should be mailed to this address: _____

REDISCLASURE:

Since information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that disclosure is permitted or required by these laws.

REVOCAATION AND EXPIRATION:

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the Area Program/LME's Notice of Privacy Practices, a copy of which has been given to me.

If not revoked earlier, this consent shall be valid for one year from the signed unless otherwise indicated below.

(Date of expiration, if less than one year) _____ (Event, if less than one year)

Notice of Voluntariness:

I understand that I may refuse to sign this authorization form. I understand that Precious Haven, Inc. will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

Signature of Client _____ Date _____ Witness (required if symbol or mark is used by client or LRP)

Signature of legally responsible person _____ Date _____

Please explain LRP authority to act on behalf of the client:

Power of Attorney _____ Guardian _____ Staff Signature _____
Other: _____

Client Record # _____

Provider Choice Agreement

Consumer Name: _____

I have received information regarding services that I am eligible to receive. I have been informed of providers from whom I am eligible to receive such services. Based upon this information, I have made an informed choice of the services and providers.

I understand that by completing and signing this form, I choose, Precious Haven, Inc. as my services provider (service specified below):

- _____ Intensive In-Home Services
- _____ Individual Outpatient Therapy Services
- _____ Family Therapy Services
- _____ Residential Level III Services
- _____ Community Support Services

Consumer Signature Date

Legally Responsible Person Signature Date

Client Record # _____

Face Sheet

First _____ Middle _____ Last _____

Social Security # _____ Date of Birth: _____

Race: _____ Gender: _____

Marital Status: _____ (s-single; m-married; d-divorced)

Admission date: _____ Discharge date: _____

Diagnosis:

- Axis I: _____
- Axis II: _____
- Axis III: _____
- Axis IV: _____
- Axis V: _____

Screening and Assessment date: _____ (if available)

Treatment/Habilitation Plan date received: _____ (if available)

Client Signature: _____ Date: _____

Legally Responsible Person Signature: _____ Date: _____

Witnessed By: _____ Date: _____

Client Record # _____

Emergency Contact Information:

Consumer Information:

First Name _____ Middle Name _____ Last Name _____

Address _____ City _____ State _____

Person to be Contacted:

Telephone Numbers (of person to be contacted in case of sudden illness) _____

Name of Person to be contacted _____

Address of Person to be contacted _____

Client's Preferred Physician Information:

Name of Physician _____

Address of Physician _____

Telephone Number of Physician _____

Client Record # _____

Admissions Assessment:

First _____ Middle _____ Last _____

Social Security # _____

Date of Birth: _____ Race: _____ Gender: _____

Client's Presenting Problems: _____

Client's Needs: _____

Client's Strengths: _____

Diagnosis:

- Axis I: _____
- Axis II: _____
- Axis III: _____
- Axis IV: _____
- Axis V: _____

Pertinent Social/Family/ Medical History: _____

Evaluations or Assessments (i.e. psychiatric, substance abuse, medical or vocational): _____

Strategies to address client's presenting problems: _____

Client Signature: _____ Date: _____

Legally Responsible Person Signature: _____ Date: _____

Witnessed By: _____ Date _____

Membership of the

Organization

Board of Directors

Administrator

LCSW

QMHP

Associate Professionals

Para Professionals

Residential Technicians

Services Provided

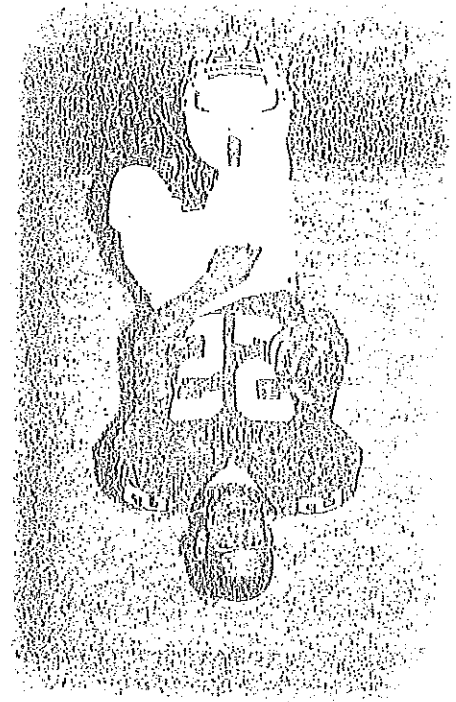
Residential Treatment

Child Placement Agency

Diagnostic Assessments

Our Government

Precious Haven, Inc. embraces diversity. Our commitment to children—regardless of race, color, or creed. The practice of discrimination of any form is not tolerated. Honor, dignity, respect, and courtesy are the driving forces of our agency. Family involvement, welcomed, expected, and appreciated.



Members Have Fun

PH

Embracing Diversity
Inspiring Positive Change



*"Treating others as we
would like to be treated"*

6302 Raeford Road

Fayetteville, NC 28304

Office (910) 868-6092

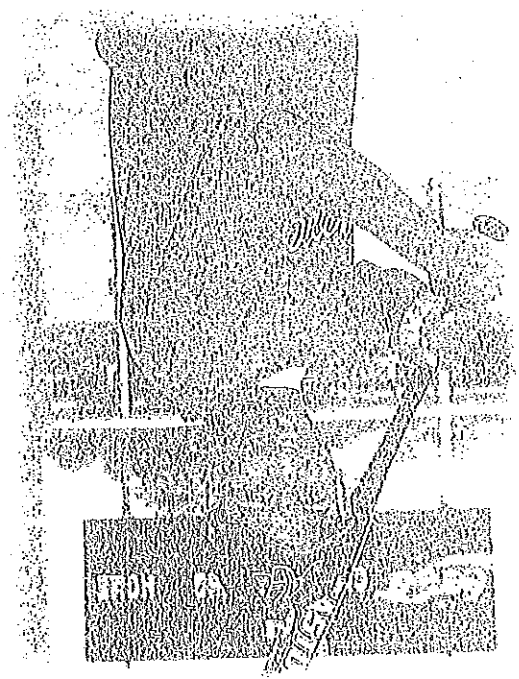
Fax (910) 868-8882

Melissa McAllister, Administrator

precioushaven@aol.com

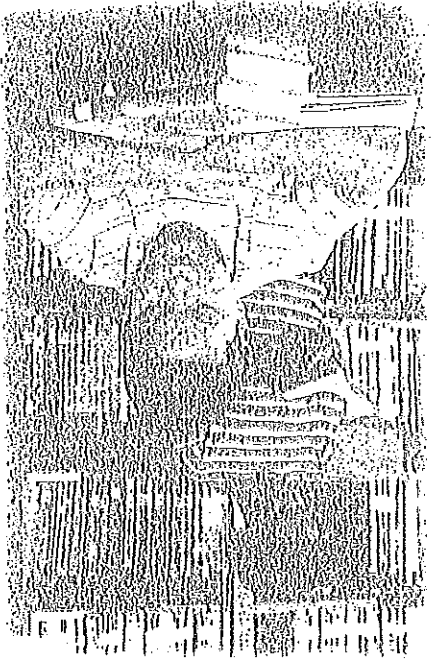
www.precioushaven.com

Precious Havens's Mission is to help children become productive members of society. We offer children the necessary time, structure, attention, and nurturing needed to encourage positive actions and interactions.



Mission Statement

Precious Havens's program components are designed for the redirection of inappropriate behavior and the improvement of academic performance. Offering children choices and rewards, and as well as holding them accountable via consequences for inappropriate behavior, help encourage independence, productivity, and responsibility. A Board of Directors oversees our program.



Program Components

Due to Behavioral and Emotional challenges often diagnosed in the children we serve, the members of our organization have designed the following therapeutic supports to assist children with these areas of need:

Anger Management

Behavior Modification

Social Skills Enhancement

Conflict Resolution

Decision Making

Alcohol & Substance Abuse Supports

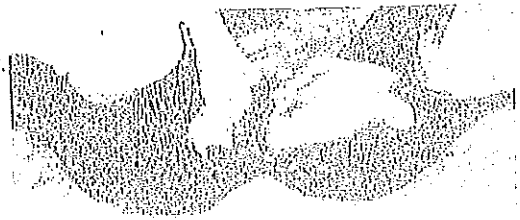
Individualized Tutorials

Daily Behavioral Logs

(Signed by Teachers as needed)

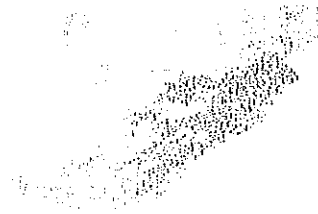
Services

Precious Havens



Precious

Precious Haven, Inc.



Dear Parent/Guardian,

Precious Haven, Inc. is a Residential

Treatment Facility for high-risk children and

adolescents. The children we serve are often

behaviorally and/or emotionally challenged,

and therefore demand consistent structure,

time, and attention. Our program offers just

that. We are dedicated to children, and the

members of our organization work diligently to

provide exemplary services to them.

Our organization consists of a Board of

Directors, Administrator, Residential

Technicians, Consultants, and Licensed

Professionals—all of whom share a passion for

children.

We consider our organization at the

cutting edge of the human services field. As

such, we have designed our program to offer

numerous therapeutic supports to aide children

behaviorally, socially, and academically.

We are proud to say that education is a

high priority, and we therefore place emphasis

on a child's success in this field. We offer

individualized tutorials, designed by our

Educational Specialist, to assist the child in their

academic performance.

We feel that no child is beyond help, and

we therefore graciously look forward to serving

your therapeutic needs.

Sincerely,

Precious Haven, Inc. Management